Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Month JANUARY 2011 8:50 PM RAYMOND DAVID L Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FREDERICK FREDERICK FREDERICK MEMORIAL HOSPITAI If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days (Month, Day, 1 XM 2 - F Months Hours Voar Director 213-44-4923 67 Maryland Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a State 10b. County 10c. City, Town or Location 10d Inside City Limits filed within 72 hours after death with the Maryland Director 1 Yes 2 X No Frederick Union Bridge Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 13416 Liberty Road 21791 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces? Black White etc. þ 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates.1965-69 3 Widowed 4 Divorced Specify: White Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) pernit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 12 fireman county government Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Catherine Nalley George Raymond 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda M. Raymond/ wife 13416 Liberty Rd. Union Bridge, MD 21791 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Resthaven Mem. Gard. 1/14/2011 Frederick, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Funeral Service Licer 22. Name and Address of Facility Hartzler Funeral Home Libertytown, MD 21762 11802 Liberty Rd. Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ungestive Physician/ Medical resulting in death) Due to lor consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? for Month Pregnant at time of death 5 Other (specify) 2 No g 🗌 Unknown g Unknown Division of Vital Records, P.O. cate has been signed by a page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an After this certificate has I autopsy performed? 25. Was case referred to medical examiner? completed filled in by the funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No ٩ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at work?
1 ☐ Yes 2 ☐ No Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred iniury 1 Natural 5 Pending Investigation Accident To the Hospital or Attend within 24 hours after deatl To the Funeral Director... 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title certifie 29c. License number 29d. Date signed (Month, Day, Year)

MIL

30. Name and address of perso

31. Date filed (Month, Day, Year)

Stran

DHMH 17 Rev 7/2009

State Registrar 400

who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Sim

MDD 71291

Frederick

7th St

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death JANUARY 9 Day 2011 Physician/ MARGARET ELIZABETH ROE 11:04 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner TALBOT HOSPICE HOUSE EASTON TALBOT If Under 1 Year Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 M 2 K F 85 8/28/1925 Director 213-22-6761 MARYLAND Usual Residence of Decedent 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hyglene. and I file 27 is marked other than "natural", or items 23a or 28a-f sho and I file 27 is marked other than "natural", or items 23a or 28a-f sho ury or other traumatic event, the Medical Examiner must be notified at ury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28a-f sho must be notified at Director 1 X Yes 2 No MD TALBOT **EASTON** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5 JUDAS STREET 21601 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ★ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: WHITE Specify: 3 X Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) CUSTODIAN 11 MAINTENANCE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ဂ္ဂ GEORGE L. JACKSON ETHEL MCQUAY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LORI R. MCNABB, DAUGHTER 4813 WHITE MARSH ROAD, OXFORD, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. SPRING HILL CEMETERY 1/17/2011 4 Donation 5 Other (Specify) EASTON, MARYLAND Signature of Funeral Service Licensee 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P
200 SOUTH HARRISON STREET, EASTON, MD 21601 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final -Ph, sician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions. if any leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Cause (Disease or iinjury been signed by the attending physician and should be detached for use as the burial-tran that initiated events Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 mooths?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Year Month Day Pregnant at time of death Other (specify) g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed this certificate has ral director, page 2 filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other 2 No Toust 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 12 Natural injury 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person Mio completed cause of death (Item 23a) (Type, Print) 508 IDLEWILD AVENUE, EASTON, MD 21601 ROBERT B. SANCHEZ 31. Date filed (Manth, Day, Year) 2011 32. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Physician/ 2011 4:28 РМ January Robert L. Rhoades Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Adventist Hospital Montgomery Takoma Park If Under 1 Year | If Under 24 Hrs. 6. Sex Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral (Month, Day, 1 X M 2 D F Days Hours Washington, DC **Director** 65 945 578-58-1800 Oct. Usual Residence of Decedent show 10a, State 10b. County 10c. City, Town or Location with the Maryland 10d. Inside City Limits Examiner must be notified at Director 1 🗆 Yes 2 🖁 No 28a-f Marvland Frederick Ijamsville 10e. Street and Number ò 10f, Zip Code 10g. Citizen of What Country? 23a Funeral 21754 USA 3402 Hummingbird Court items ; 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian, Armed Forces' Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 🕅 Married 1 X Yes 2 No 1966— If Yes, Give "natural", or δ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Completed 3 Widowed 4 Divorced 1968 White Year or Dates. event, the Medical Decedent's Education 16a. Decedent's Usual Occupation 16h Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene.
is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Industrial Technology <u>Salesman</u> Be 17. Father's Name (First, Middle, Last) Page 1 and 2 should be filed 18. Mother's Name (First, Middle, Maiden Surname) ည Arthur C. Rhoades Minnie Hanbank 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health item 27 i Katharine Rhoades / Wife 3402 Hummingbird Court, Ijamsville, MD 21754 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite cemetery, crematory or other place) Injury or 4 ☐ Donation 5 ☐ Other (Specify) Stauffer Crematory 1/14/2011 Frederick, Maryland 21. Sign Vre of Funeral Service Licen Stauffer Funeral Home 22. Name and Address of Facility any 1621 Opossumtown Pike, Frederick, MD 21702 e, or complications that roused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. 23 a. Part 1. Enter the disease chock, or heart failure Approximate Interval Between Onset and Death Immediate Cause (Final Qiysician/ SEPTIC disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner OGENES Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying and -transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): bunial-1 attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has performed certificate 1 Yes 2 No Yes 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Other: 1 🗌 Yes 2 **N**No မ 1 Nnpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes Certificate: 28d. Describe how injury occurred injury 1 XNatural 5 Pending 24 hours after death. Funeral Director: A 2 No Accident Investigation completed filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 🔲 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the 1 only one) 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year)

Registrar

State

MAPLE

TAKOMA PARK, MARYLAND

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

MD

7901

strar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death JANUARY 16, 2011 9:15 Physician/ **AUGUSTA** SUNDAY MARTHA Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner FREDERICK FREDERICK GOLDEN ASSISTED LIVING 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. **Funeral** 1915 GERMANY Days Hours Min. 95 <sup>e</sup>21, 1 🗆 M 2 🗶 F JANUARY Yrs. **Director** 212-01-5128 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location. 10a. State items 23a or 28a-f sho her must be notified at Director MD. TANEYTOWN CARROLL 1X Yes 2 ☐ No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ed other than "natural", or items 23a or event, the Medical Examiner must be USA Funeral 21787 157 SADDLETOP DRIVE 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 14 Race - American Indian. 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: WHITE 3 X Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. is marked other than College (1-4 or 5+) Page 1 and 2 should be filed within 7 ment of Health and Mental Hygiene. ant: If item 27 is marked other thar Elementary/Seconday (0-12) OWN HOME HOMEMAKER 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ AUGUSTA BREMS ROBERT HOFMANN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 157 SADDLETOP DRIVE, TANEYTOWN, MARYLAND 21787 LORRAINE MOALE/DAUGHTER or other 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Page 1 a
Department of IImportant: If ite
any injury or ot 1 Burial 2 X Cremation 3 X Removal from State 1/18/2011 FALLS CHURCH, VA. NATIONAL CREMATORY 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility EDWARD SAGEL FUNERAL DIRECTION, 21. Signature of Funeral Service Licensee 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852 Greenhos MO1597 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ATHEROSCLEROSIS CORONARY ARTERY DISEASE Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner LIPOSARCOTIA Sequentially list conditions. Due to (or as a consequence of): Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Day Pregnant at time of death signed by the a g 🗌 Unknown g 🔲 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown 2 🗌 No completed filled in by the funeral director, page 2 should l 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 After this certificate I 2 🗌 No Yes 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner?
1 Yes 2X No Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6X Othe ျ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury\_at 28d. Describe how injury occurred Certificate: 1 XNatural 5 Pending 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation s after death 6 Could not be 28f. Location (Street and Number or Rural Route Number, 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) City or Town, State)

State

24 hours

To the I

13

Medical

29a. Certifier

(Check

only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

2 0

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SIBTE A. KAZMI, MD 814 TOLL HOUSE AVE. FREDERICK, MARYLAND 21701

32. Registrar's Signature

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D47951

29c. License number

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

/18/2011

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Physicia edical Exami	an/	Decedent's Name (First, Middle, L	ast) Donald	S	ander					Date of De Month January	Day	Year 1		3. Time of Death 1722 hrs
		4a. Facility Name (if not institution, g 702 Chaney Drive			11111		own, or Lo	ocation of	Death			: County of Montgom		
Funeral		Social Security Number     6.	If Under 1 Year If Under 24Hrs.				3. Date of E	Birth (MM/		9. Birth Foreign	place (State or			
Director		219-54-9812	X M 2 F 60		Yrs	Months	s Days	Hours	Min.	05/2	6/19!		Cour	
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215-0036 be filed within 7 ntal Hygiene.		17. Father's Name (First, Middle, La	st)	<u>-</u> -			18	3.Mother's	Name (F	irst, Middle	, Maiden	Surname)		
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Baltimore, permit. Pages I ar Department of Hee Important: If ite injury or other tr		1 Burial 2 X Cremation 3		.0			emat	ory (	01/13	3/201	1 Br	entwo	od.	Maryland
Balti permit. Departm Imports injury o		21/Signature of Funeral Service Lice		100	22. N	lame and	Address o	of FacilityS	impl ente	e Tri	bute	Fune	ral	& Cremation
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/Medical		failure. List only one cause on					, ,,							Between Onset and Death
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	-6	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a conse	quence of):										
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cath certificate be extated by attending physician for use as the burial.	Physician/Medic	past 12 months?	4 Pregnant at t	me of deat	h - H	tal death her <i>(Spec</i>		_caopic p	i egilaric			WOITH	Da	ly real
Bo he deat the at hed for	hys	1 Yes 2 No 9 Unknow Part II. Other significant conditions	9Onknown	<b>.</b>	Initial in the co			an in Dark		I 220 Did	tobacco	usa santrib	uto to th	e cause of death?
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ion of tending Pheath.	Certification:	1 Natural 5 Pending 2 Accident Investige	FOUND: Day,Ye	ar)	OUND: 1710 hrs	ijui y		s 2 🗹 N	Si					building
Pending Investigation Jan 5, 2011 1710 hrs 1 Yes 2 No 1710 hrs 1 Y														
Division of Vital Records, P.O. Box 68760,  To the Hospital or Attending Physician: The law requires that the death certificate be exe within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician is completely filled in by the funeral director, page 2 should be detached for use as the bunial.		Torroan only	ician: To the best of my	knowledge	, death occur				e, and du	e to the ca	use(s) an	ıd manner a	as stated	1.
To th withi To th	Medical	29b. Signature and title of certifier	and manner stated.	auvii aiiQ	o investigat		License r		med at II	o unie, uat		_		h, Day, Year)
	ೌ	Paniet Privitial	1, nels			255.	O.C.M					uary 6, 2		,,,,,
		30. Name and address of person who Pamela E. Southall, MD	•			W. Bal	ltimore :	Street.	Baltimo	ore, MD	21223			
		,												

DHMH 17 Rev 1/2001 OCME 2006

State Registrar

32 Registrar's Signature

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death Month Day Year **Physician** 950M 201 /Medical 4c. County of Death 4b. City, Town, or Location of Death Examiner alisbu Wicomico en Birthplace (State or Foreign Country) vrs. last birthday If Under 1 Year **Funeral** Months 1 2 M 2 □ F Yrs. Pennsylvania Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Mcdical Examinar must be rutified at 28a-f show 1 ☐Yes 2X No Pittsville Directo Wicomico Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21850 5296 Morris Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 NoArmy/ 1 MYes 2 NoArmy/
If Yes, Give AirCorp 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: white 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education filed within 72 (Specify only highest grade completed) Elementary/Secondary (0-12) Pages 1 and 2 should be filed within ment of Health and Mental Hygiene. Int: If item 27 is marked other than ' College (1-4or 5+) steel salesman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) å Genevieve Welch Jacob Albert Schaffner ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Michael J. Schaffner/son 5296 Morris Rd., Pittsville, MD 21850 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Important: If its any Injury or o 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Salisbury, MD Salisbury Crematory 1/18/2011 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 2 yrs plus **Physician** Advance deme /Medical Due to (or as a consequence of): Examiner FR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine or Attending Physician; The law requires that the death certificate be executed anem Chronic and burial-tran Due to (or as a consequence of): Box 68760, cate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) P.O. | 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ≥ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No certificate 1 ☐ Yes **Division of Vital** funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After t 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No ours after death.

neral Director; A 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral D Hospital 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) npletely (Check only and manner stated. the 29d. Date signed (Month, Day, Year)

State Registrar

Michael P. Buchness M.D. 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

Hoad Hospital, Salisbu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Shockley Harold Thomas Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner HICOMION If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Funeral Days (Month, Day, Year 1 **X** M 2 □ F Months Hours Min. 72 215-36- 1184 Director 10/22/1938 Maryland Usual Residence of Decedent show 10b. County 10d. Inside City Limits 10c. City. Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked of other than "natural", or items 23a or 28a-f sho uny or other traumatic event, the Medical Examiner must be notified at ury or other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 X No Snow Hill Worcester Maryland 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Completed by Funeral USA 21863 5030 Spencer Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11, Marital Status 14 Race - American Indian Black, White, etc. Yes 2 X No Yes, Give 1 Never Married 2 X Married Maryland 21215-0036 Yes 2 No Specify: Specify: white 3 Widowed 4 Divorced Year or Dates 16a Decedent's Usual Occupation 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) agriculture owner/operator Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ္ Eloise Bradford Arthur Lee Shockley 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5030 spencer Rd., Snow Hill, MD 21863 19a. Informant's Name/Relationship (Type, Print) Lois Shockley/spouse Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of Date Department of I Important: If its any injury or ot cemetery, crematory or other place) 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 1/19/2011 Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory AdTroway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each ine. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to lor as a consuluence of To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death nse 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months?
1 ☐ Yes 2 ☐ No Year Pregnant at time of death detached the Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ate has been signed page 2 should be de Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No death? certificate 2 🗌 No 1 Yes completed filled in by the funeral director, Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Hospital Other: 2 No ER/Outpatient 3 DOA 욘 1 🗹 Inpatient 2 🗌 4 Nursing Home 5 Residence 6 Other (Specify) this Man of Death s after death. 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) Natural Pending 1 🗌 Yes 2 🔲 No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one 29b. Signature and title of certifie

State Registrar 30. Name and address

31. Date filed (Month, Day, Year)

completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) <sup>D</sup> 1 6 2 0 1 1 January Physician/ 1:50 PM Dennis Granville Smith Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Hyattsville St.Thomas Moore Nursing Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** Mar. 26, 1946 Min. 1 🔀 M 2 🗆 F Halifax Co.NC 1602 64 578 66 **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County within 72 hours after death with the Maryland an "natural", or items 23a or 28a-f sho Medical Examiner must be notified at Director 1 X Yes 2 No DC Washington 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 20002 USA 901 21st Street Apt. #11 Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. Armed Forces þ 1 Never Married 2 Married ☐ Yes 2 X No Yes, Give Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black 3 ₩ Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Apt. Complex the Custodian 7th Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Rose Moore Dennis G. Smith, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3005 Bladensburg Rd.NE Apt#906 Wash.,DC20018 Mary Smith/ Sister Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 X Buriai 2 Cremation 3 Removal from State 1/22/2011 Scotland Neck, NC any injury or Staton Cemetery 4 Donation 5 Other (Specify) 22. Name and Address of FacilityNew Beginnings Funeral Serv. 21. Signature of Funeral Service Lice West 5th Street Scotland Neck, NC 27874 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. interval Between Onset and Death Immediate Cause (Final VINUS INFOCKER enysician/ Duman moundeficiency disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or as a consequence of) if any, leaving to immediate cause. Enter Underlying Cause (Disease or iinjury • Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
• Funeral Director: After this certificate has been signed by the attending physician and leted filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 9 Unknown 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an performed 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 2 No Hospital 1 Inpatient 2 ER/Outpatient 3 DOA ဂ္ 1 🔲 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 3 🗌 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar 13

31. Date filed (Month, Day, Year)

JAN20

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician/ 1842M Smith hnuar 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner The Memorial aital Eastor Talbot TOS If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year Funeral Days 1 M 2 M F Min Maryland 0 3 - 0 6 ay, 1 9 32 Director 78 215-40-4850 Usual Residence of Decedent 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Director or 28a-f sh notified a Md. 1 Yes 2 No Baltimore 0 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? must be 23a Funeral 1735 Druid Hill Ave. 21217 USA items 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status permit. Page 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner. Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black 3 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Education Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Smith Anna 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Grand-Jennifer McKnight/daugthe Padua way, Mills.Md. Owings 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Woodlawn Park 01 - 15 - 11Easton, Md. 4 Donation 5 Other (Specify) 22. Name and Address of Facility Bennie Smith Funeral Home . Signature of For ral Service License Easton Md 426 Dover St art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Interval Between Onset and Death shock, or heart failure. List only one cause on each Immediate Cause (Final ongestive Heast Physician. disease or condition resulting in death) Medical Due to (or / a consequence of): Examiner Aostic Ce vere Sequentially list conditions Examiner ii any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence off. Anoxic Hospital or Attending Physician. The law requires that the death certificate be executed the attending physician and ned for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Kidner LOONIC Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ Month Day Year Pregnant at time of death 9 Unknown 9 Unknown P.O. completed filled in by the funeral director, page 2 should be detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 2 ☑No 3 ☐ Probably 4 ☐ Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) **Division of Vital** Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🖾 № 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: To within 24 hours after death.

To the Funeral Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie (Check the only one) 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) D0069567 Mohan Jan, 10, 2011 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Washington Street, EASTUR Md. 21601 Registrar's Signature State JAN 13 2011 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Month Day Physician/ :35 01 arles Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Town, or Location of Death **Examiner** Humo/e 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Min 1 **X** M 2 □ F Months 50 08/16/1960 214-80-5530 MD Director Usual Residence of Decedent 10d. Inside City Limits 28a-f shov 10b. County 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State Director 1 Yes 2X No MD TALBOT EASTON 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral UNITED STATES 21601 8804 BLACK DOG ALLEY Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. ģ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Specify: WHITE 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) FASTENER AND SUPPLY **SALESPERSON** Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၀ RUTH ANNA KEMP JAMES ROLAND SMITH 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 31913 BLADES ROAD, CORDOVA, MD 21625 DONNA L. SHORTALL / SISTER 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
CHESAPEAKE CREMATION
CENTER
01/12/2011 1 Durial 2 X Cremation 3 Removal from State STEVENSVILLE, MD 4 Donation 5 Other (Specify) . Signa FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 200 SOUTH HARRISON ST., EASTON, MD 21601 hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complications to shock, or heart failure. List only one cause of Approximate Interval Between and Death Immediate Cause (Final Physician/ utra cerebra days disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Secus tially let conditions if any, leading to immediate cause. Enter Underlying Examine Due to for as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Cause (Disease or linjury that initiated events resulting in death) Last attending physician and Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 the IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death use 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year be detached for Pregnant at time of death 5 Other (specify) 4 Pregnant 9 Unknown 9 Unknown signed by Part I<mark>I. Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> 2 No 3 Probably 4 X Unknown Completed page 2 should peen s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 1 ☐ Yes 2 ☐ No After this certificate director. 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 X No ပ 1 Yes 1 X Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: X Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) TVS 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8 ewis Date filed (Month) JAN 12 2011 Registrar's Signat State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Month Wanda **Physician** January 16 2011 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** The Johns Hopkins Hospital **Baltimore City** Baltimore 8. Date of Birth (Month, Day, Year) Aug. 5,1959 5. Social Security Number 6. Sex Age (In yrs. last birthday) **Funeral** Months 216-76-1647 51 Director Usual Residence of Decedent 10c. City. Town or Location 10a. State 10h County ral", or items 23a or 28a-f show Examiner must be notified at Director Maryland Montgomery Damascus 10e. Street and Number 10f. Zip-Code 10g Citizen of What Country? 20872 8310 Gue Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▮
If Yes, Give
Year or Dates: and 2 should be filed within 72 hours after leath and Mental Hygiene. 1 ☐ Never Married 2 ■ Married 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No 2 Specify: 3 Widowed 4 Divorced "natural", Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry traumatic event, the Medical (Give kind of work done di life. DO NOT use retired) during most of working (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) is marked other than 11 Food Restaurant Owner 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Betty E. Howard William Mills 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2
Department of Health a
Important: If item 27 is
any Injury or other trau Richard K. Stanley/ Husband 8310 Gue Road, Damascus, MD 20872 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Jan.20,2011 Mt. Airy, Maryland Howard Chapel Cem. 22. Name and Address of Facility
Molesworth-Williams, P.A., Funeral Home 21. Signature of Fungal Service Licensee 26401 Ridge Road, Damascus, Maryland 20872 used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Ent r the disease, r cor shock, or heart failure. List only Immediate Cause (Final J131 **Physician** 05 ئ disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) attending physician and I for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) Live birth 2 Fetal death in the past 12 months?

1 Yes 2 No
9 Unknown Month 4 Pregnant at time of death ate has been signed by the a page 2 should be detached P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ş Records, 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No certificate Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 Inpatient examiner? Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) 2 X No 3 🗆 DOA 1 Yes 2 ER/Outpatient ٩ 28a. Date of Injury (Month, Day Year) completely filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural Certification: I or Attending F after death. Director; After t 5 Pending investigation Injury 1 Yes 2 No Accident 3 Suicide Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide To the Hospital of within 24 hours a To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifiei Medical (check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier RES-000 January 16, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3. Time of Death

Birthplace (State or Foreign Country)

Maryland

White

Service

Approximate Interval Between Onset and Death

Day

600 North Wolfe St, Baltimore, MD, 21287

Year

10d. Inside City Limits

1 Yes 2 No

4:52 PM

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day

-in

32. Reai

rar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 15<sup>Day</sup> Physician/ Month 201<sup>Year</sup> Edith Erica Slacum 2:50P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Kline Hospice House Mt. Airy Frederick 5. Social Security Number 7. Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral 8. Date of Birth Months Days Min 1<sup>M</sup>/2<sup>h</sup>1<sup>D</sup>/1<sup>Y</sup>9<sup>r</sup>30 Director 161-30-5949 80 Yrs Germany Usual Residence of Decedent 28a-f shov 10a. State 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Frederick Middletown 1 X Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 110 Rhoderick Circle 21769 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🙀 No If Yes, Give Year or Dates. er than "natural", c , the Medical Exam 1 ☐ Yes 2XXIIo Specify: Specify: White ¾¥Widowed 4 □ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) homemaker own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental H is marked of ပ္ Bruno Von Goscinski Anna Endler 19a. Informant's Name/Relationship (Type, Print) Peggy Throne (Daughter) 19b Mailing Address (Stra 201 Stone et and Number or Rural Route Number, City of Town, State, Zip Codel Springs Ln, Middletown, MD 21769 permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Smithsburg Crematory or Cher place) tory1/17/2011Smithsburg, 21. Signature of Foneral Service Licensee Donald Home Pob 18, Middletown, MD 21769 Ma MURRY 23a. Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final THE LUNG Onset and Death Physician/ DENOCARCINOMA of disease or condition resulting in death) MONTHS Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): Exami attending physician and for use as the burial-transit requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery yes, other of pegnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No Month Day signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 □ No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law page 2 has autopsy performed? Yes 2 ☐ No 1 Tes funeral director, 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Hospital: 1 Tes 2 No Other: KLINE HOUSE 잍 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🗹 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5  $\square$  Pending s after death.

I Director: Aft and in by the fur 2 Accident
3 Suicide
4 Homicide 1 Yes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) 031 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BRIAN M, O'CONNOR 501 CN, SELENTA

State Registrar 31. Date filed (Month, Day, Year)

Maryland 21215-0036

Baltimore,

Box 68760

P.O.

Records,

Division of Vital

5%

MD

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State Registrar	te of Maryland	d / Depa		of He	ealth a		ental Hyg	jiene leg. No.	Make and the state of the state	03013		
			Decedent's Name (First, Middle, Last)							2. Date of Dea Month	th Day	Year	3. Time of Death		
	Physicia									January		2011	9:45A M		
>	/Medic Examin		4a. Facility Name (If not institution, give street and number) 4b. City, Town, o						f Death		4c. Cou	nty of Death			
	*-	<u> </u>	9812 Meadowcroft La	ne		Ga:	ithe	rsbur	g			Montgomery			
	Funeral		5. Social Security Number 6. Sex	If Under		If Under 2 Hours	Min.	8. Date of Birtl (Month, Day	r, Year)	Cou	place (State or Foreign intry)				
L	Director		212-68-2096				Sept. 6	1954	1954 California						
	pug w	1	Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or Lo	cation							10d. Inside City Limits		
	/anyle	5	Md. Montgomery Gaithersburg										1 ☐ Yes 2 🖺 No		
	28a-	Director	10e, Street and Number			10f. Zip	Code				10g. Citizen	of What Cou	intry?		
	with Sa or		9812 Meadowcroft Lane					886			Un	ited S	States		
	ms 2;	era	11 Marital Status 12. Wa	11 Marital Status 12. Was Decedent Ever in U.S.				panic Orig	gin? (Spec	cify Yes or No- lican, etc.)	- 14. Race - American Indian, Black, White, etc.				
9	after or ite	by Funeral	1 Never Married 2 Married 1	ned Forces? ]Yes 2⊠No es, Give		1 ☐ Yes 2		Specify:	1, 1 001101	iloari, oto.,			White		
8	rel', c		3 Widowed 4 Divorced Yes	ar or Dates:											
5	72 h 'natu	Completed	15. Decedent's Education (Specify only highest grade comp	leted)	16a. Dece (Give	dent's Usua kind of wor DO NOT us	Cocupa k done d	tion <i>uring m</i> osi	t of workin	g	16b. Kind o	f Business/II	ndustry		
2	vithin ne. <b>han</b>	mp		lege (1-4or 5+)							По	1100 Pr	ainting		
N T	ited v Hygie ther t	ပိ	12 17. Father's Name (First, Middle, Last)		Р	ainte:		18. Mothe	er's Name	(First, Middle,			illicing		
and	d be f antal h	) Be	George James Spire	0					oris	Ophel:					
2	should nd Me mark matir	으	19a. Informant's Name/Relationship (Type, Pri		19b. Mailir	ng Address	(Street a	nd Numbe	er or Rural	Route Numbe		wn, State, Z	ip Code)		
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "naturel", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examinal must be notified at once.		Kathy A. Spiro / Wi	fe	9812	Mead	owcr	oft I	Lane,	Gaithe	ersbur	g, Md.	. 20886		
ē,	s 1 a of Hea item othe		20a. Method of Disposition	Ce	ace of Dispo	sition (Nam matory or of	e of her place	9)	D	ate	20c. Locati	on - City or T	Town, State		
E	Page nent c int: If		1 ☐ Burial 2 【★ Cremation 3 ☐ Removal '4 ☐ Donation 5 ☐ Other (Specify)	Met	ropol	itan (	Crem	•	1/22	/11	Alex	andria	a, Va.		
aĦ	permit. Departn Importe any inju		21. Signature of Funeral Servic Lice 69		22	Name and	d Addres	s of Facilit	ther	Funeral Laytons	Home				
<u> </u>	82553		1016 anda	M-004								, Md.			
Г			23a. Part1. Enter the disease, or complications shock or heart failure. List only one cause	s that caused the death se on each line.	. Do not ent	er the mode	of dying	, such as	cardiac or	r respiratory ar	rest,		Approximate Interval Between Onset and Death		
	Pnysician		Immediate Cause (Final disease or condition	Amyotrophi	c Lat	eral S	Scle	rosis	3						
	/Medical Examiner		resulting in death)	Due to (or as a consequ	ience of):										
П		<u>-</u>	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury									_			
	uted I Insit	Examiner													
Ć	e be executed /sician and e burial-transit	Еха	that initiated events c. resulting in death) Last Due to (or as a consequence of):												
1760,		cai	d												
89	ing ph	Physician/Med	IF FEMALE:												
Вох	ath ce ttendi	lan/	23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy								23d	Date of deli Month	very Day Year		
0	the a	/sic	1 Vos 2 DNo	4 Pregnant at time of death 5 □ Other (specify) 9 □ Unknown											
Д	that the de led by the a detached to	Ph	Part II. Other significant conditions contributi	ng to death but not resu	alting in the u	inderlying c	ause give	n in Part I	l.	23e. Did t	Did tobacco use contribute to the cause of death?				
ecords,	The law requires that the death certifical site has been signed by the attending phy age 2 should be detached for use as the	d by			_		-			10	Yes 2 1				
Sor	w requ	Completed								24a. Was	an 2	4b. Were au	itopsy findings available		
Re	The lav	dimo									osy ormed? 2 No	prior to death?	completion of cause of 2□ No		
tal		Be Co	25. Was case referred to medical					26. Place	e of Death	1 ☐ Yes		1 2 103	20110		
of Vital		0	examiner? 1 ☐ Yes 2 ₹ No Hospita	d: 1 ☐ Inpatient 2 ☐	ER/Outpatie	nt 3 DC	)A Othe	er: 4 □ Nu	ursing Hor	ne 5⊠Resi	dence 6	Other (Spec	cify)		
10	ng Phys ter this neral di	n: T	27. Manner of Death 1 Natural 5 ☐ Pending	. Date of Injury (Month, Day Year)	28b. Time o	of 2	8c. Injury Work	at		28d. Describe					
<u>i</u>	Attending r death. sctor: After by the fune	atic	2 Accident investigation	1 🗆 '	Yes 2□										
Division	or Atter ter de irecte n by t	ertification:	3 ☐ Suicide 6 ☐ Could not be determined 286	<ul> <li>Place of Injury - At he building, etc. (Specify)</li> </ul>		reet, factory	, office			28f. Location ( City or To		lumber or Ru	ural Route Number,		
Ω	Hospitel or 4 hours afte Funerel Dir tely filled in I	O	20 Carific Affication Physician	To the heat of my kno	wladaa daa	No a constant	at the tim	and data as	nd piaco r	and due to the	causa(s) an	d manner as	stated		
	To the Hospitel or Attending F within 24 hours after death.  To the Funerel Director: After completely filled in by the funer.	edical	29a. Certifier 1  Certifying Physician (Check only one) 2 Medical Exeminer: 0	n the basis of examinated manner stated.	tion and/or in	rvestigation	, in my o	pinion, dea	ath occurr	ed at the time,	date and pla	ace, and due	to the cause(s)		
	ro the vithin o the comple	Me	29b. Signature and title of certifier			290	. License	number					h, Day, Year)		
	F > F 0		> Clauston ay	sun			D	3979	3		Ja	nuary	17, 2011		
	10		30. Name and address of person who complet		23a) (Type	, Print)				0.7	M 1	20022			
_	Ψ		Christopher J. Mays	P				Lip .	Dr.,	Olney,	• DIM	20832			
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signa	iture A.	for	Kal								
	Regist	al	OHIO - C	/	*	1									

11-00590

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Cara Nicole Thornto	1-	State of Marylan		rtment of tificate of		and	Mental		Reg. No.	1 10014		
Physician/ Medical Examiner	1.	1. Decedent's Name (First, Middle, Last)  Cara Nicole Thornton  Cara Nicole Thornton  Spriggs—Thornton  2. Date of Death Month Day Year January 21, 2011										
		. Facility Name (if not institution, give street and number 317 Columbia Street #4							4c. County of I	Death		
Funeral Director	5. Social Security Number 2 1 5 - 0 6 - 0 9 4 8 6. Sex 1 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY 1 1 Months Days Hours Min. 04 / 0 6 / 1 9 8 2								F	9. Birthplace (State or Foreign Maryland Country)		
/land f show any once.	1	Usual Residence of Decedent  10a. State										
with the Maryland us 23a or 28a-f sho be notified at once be notified at once stall Director		At Page Am										
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 23a-f she injury or other traumatic event, the Medical Barminer must be notified at once To Be Completed by Funeral Director	: I :	Marital Status  Never Married 2 Married 12. Was Deced Armed Ford 1 Yes Widowed 4 Divorced If Yes, Give Year or Dates:	ces? 2 X No	1	es, specify Yes 2	Cuban, I	specify:	erto Rican, etc.)	Specify:	Black		
5-0036 ed within 72 hours tygiene. other than "natu the Medical Earn Completed	15. Decedent's Education (Specify only highest grade completed)  Elamentary/Secondary (0-12)  College (1-4 or 5+)  Student  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  Student  Beautiful Completed during most of working life. DO NOT use retired beautiful Completed during most of working life. DO NOT use retired beautiful Completed during most of working life. DO NOT use retired beautiful Completed during most of working life. DO NOT use retired beautiful Completed during most of working life. DO NOT use retired beautiful Completed during most of working life. DO NOT use retired beautiful Completed during most of working life. DO NOT use retired beautiful Completed during most of working life. DO NOT use retired beautiful Completed during most of working life. DO NOT use retired beautiful Completed during most of working life. DO NOT use retired beautiful Completed during most of working life. DO NOT use retired beautiful Completed during most of working life. DO NOT use retired beautiful Completed during most of working life. DO NOT use retired beautiful Completed during most of working life. DO NOT use retired beautiful Completed during most of working life. DO NOT use retired beautiful Completed during most of working life.								Beaut	y School		
MD 21215-0036 12 should be filed within 7 th and Mental Hygiene. 127 is marked other than unmatic event, the Medica. To Be Comple		'. Father's Name (First, Middle, Last) Ralph Upton		Spriggs			Carol	Le		Pope		
MD 21 12 should th and Me 127 is ma umatic ev	F	a Informant's Name/Relationship (Type, Print) alph U. Spriggs / Father		866 M	laryla	nd .	Avenue	, Cumber	umber, City or Town, land, MD	21502		
Baltimore, permit. Pages I and Department of Heal Important: If item injury or other tra	20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State  4 Donation 5 Other Specify:  20b. Place of Disposition (Name of cemetery, crematory or other place)  Cumberland Crematory  21. \$\frac{1}{3}\text{grature of Funeral Service Licensee}  20c. Location  20d. Date  20c. Location  20d. Place of Disposition (Name of cemetery, crematory or other place)  21. \$\frac{1}{3}\text{grature of Funeral Service Licensee}  220d. Location  221. \$\frac{1}{3}\text{grature and Address of Facility Adams Family Fune}  221. \$\frac{1}{3}\text{grature of Funeral Service Licensee}  222. \$\frac{1}{3}\text{grature and Address of Facility Adams Family Fune}  223. \$\frac{1}{3}\text{grature of Funeral Service Licensee}  234. \$\frac{1}{3}\text{grature of Funeral Service Licensee}  245. \$\frac{1}{3}\text{grature of Facility Adams Family Fune}  256. \$\frac{1}{3}\text{grature of Facility Adams Family Fune}  267. \$\frac{1}{3}\text{grature of Facility Adams Family Fune}  276. \$\frac{1}{3}\text{grature of Facility Adams Family Fune}  277. \$\frac{1}{3}\text{grature of Facility Adams Family Fune}  277. \$\frac{1}{3}\text{grature of Facility Adams Family Fune}  278. \$\frac{1}{3}\text{grature of Facility Adams Family Fune}  279. \$\frac{1}{3}\text{grature of Facility Adams Family Fune}  289. \$\frac{1}{3}\text{grature of Facility Adams Family Fune}  290. \$\frac{1}{3}\text{grature of Family Fune}  290. \$\frac{1}grature of Family								1 Cumber	erland, MD		
Balt permit. Departi Importinjury	Т	Signature of Funeral Service Licensee		40	4 Dec	atu	r Stre	et, Cumb	erland, M	ID 21502		
Physician /Medical £xaminer	ı	inculate cause (i mai alecaes = -		Do not enter tr		ayıng, s	uch as card	ac of respiratory a	Trest, Stidok, of fleat	Between Onset and Death		
	or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):											
ed nisit Examiner												
execut an and al - tra		d.  X UNPENDED X AMENDED	1,23a,2	7 per n	ne g9:	4 4	-7-11	vt				
tox 6876(eath certificate attending physe for use as the b	23	FEMALE: b. Was decedent pregnant in the past 12 months?  23c. If yes, or 1 Live bir	nt at time of de	2 Fe	tal death her (Speci	3 [ fy)	Ectopic pr	egnancy	23d. Date of d Month	elivery Day Year		
P.O. E so that the d gned by the e detached	3	art II. Other significant conditions contributing to	death but not r	esulting in the u	noerlying (	ause gh	ven in Part I.	í	_	ute to the cause of death?  Probably 4 Unknown		
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the safter death.  11 Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach entification: To Be Completed by P	Compilere							per 1 <b>✓</b> Yes	opsy pri form <u>ed</u> ? de	ere autopsy findings available or to completion of cause of eath?  Yes 2 No		
of Vital Recoling Physician: The law After this certificate has inneral director, page 2 si mr. To Be Compi	3 2	5. Was case referred to medical examiner?  1  Yes 2 No  Hospital: 1 In	patient 2	ER/Outpatient	3 DO	DA C	Other N		Residence 6			
on of cading Pt ath.  Or: After the funeral the funeral thin: T		Natural 5 Pending	of Injury Day,Year)	28b. Time of I	njury 2		at Work? es 2 No		e how injury occurred	d		
Division of Vital Rec Hospital or Attending Physician: The I 24 hours after death. Funeral Director: After this certificate I stely filted in by the funeral director, page al Certification: To Be Com		2 Accident Investigation 3 Suicide 6 Could not be determined (Specify)	of Injury - At h	ome, farm, stree	et, factory,	office bu	ilding, etc.	28f. Location or Town		r or Rural Route Number, City		
To the Hospital within 24 hours To the Funeral completely filled		Ga. Certifier 1 Certifying Physician: To the best check only 2 ✓ Medical Examiner: On the basis of and manner sta	f examination a	lge, death occur and/or investiga	red at the tion, in my	time, dat opinion,	e and place death occur	and due to the ca	use(s) and manner a te and place, and du	as stated. e to the cause(s)		
	2	9b. Signature and title of certifier			29c.	O.C.N	number 1.E.		29d. Date signed January 22,	d (Month, Day, Year) 2011		
	-	0. Name and address of person who completed cause Margarita Korell MD. Assistant Med			. Baltim	ore Str	eet, Balti	more, MD 212	223	-		
State Registra	-		gistrar's Signat	. far	al d							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number) City, Town, or Location of Death 4c. County of Death **Examiner** Ver lontacmeri . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9 Birthplace (State or Foreign Funeral 1 🗆 M 2 🔀 F Davs Hours (Month, Day, 12/31 217-27-3846 **Director** 83 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits filed within 72 hours after death with the Maryland ms 23a or 28a-f sho must be notified at Director MD Montgomery Silver Spring 1 🗆 Yes 2 🄀 No 10e Street and Number 10f. Zip Code 10g, Citizen of What Country? 901 Arcola Avenue Funeral 20902 China items 2 11. Marital Status 12 Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces? Black, White, etc. o. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Asian "natural", Completed 3 XWidowed 4 ☐ Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working t: If item 27 is marked other than 'co other traumatic event. The Nalife. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker 8 Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) .. Page 1 and 2 should be filed tment of Health and Mental Hy tant: If item 27 is marked ot Luong Tran Chang Chung 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leigh Anne Gong/Daughter 42550 Long Acre Drive South Riding, Va20152 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1 a Department of I Burial 2 ☐ Cremation 3 ☐ Removal from State Important: It any injury or 1/15/2011 4 ☐ Donation 5 ☐ Other (Specify Gate of Heaven Silver Spring, Md . Signature 🖟 uneral Service PHADER ADES RINALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Congestive heart failure Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Arrhythmia Secumbally list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🔀 No 5 Other (specify) Month Day Year Pregnant at time of death 1 Yes 2 D the care has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 XUnknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 within 24 hours after death.

To the Funeral Director: Af er this certificate I completed filled in by the funeral director, page 2 🗌 No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Hospital 2 🗓 No Other: 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🛛 Natural 5 Pending work' 1 Yes 2 🗆 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 🗋 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 00070792 1/12/2011

State Registrar 2. Registrar's Signature

1500 Forest Glen Road Silver Spring, Md 20910

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sami Mourad MD

JAN 20

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 1 per doc g941 7-19-13 yt. State of Maryland? Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Midelle, Last) 2. Date of Death 3. Time of Death Mahindokht Najmabadi Tashakori Physician/ Medical Town, or Location of Death County of Death Facility Name (if not institution, give street and number) Examiner Husda Montgomer 7. Age (In vrs. last birthday) Year If Under 24 Hrs 8. Date of Birth 9. Birthplace State or Foreign **Funeral** 1 □ M 2 🛣 Months Days Hours Min (Month, Day, Year 02/17/193 Country) 577-02-6292 Yrs **Director** Iran Usual Residence of Decedent or 28a-f show notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State be filed within 72 hours after death with the Maryland Director 1 X Yes 2 No MD Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò ıral", or items 23a o Examiner must be Funeral 7420 Westlake Terrace #1508 20817 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 X No Black, White, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 befine within 72 hours after begarnment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examin If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Completed 3 Divorced 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Zabihollah Najmabadi Aqdas Alaqa 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5101 River Road #1809, Bethesda, Maryland 20816 Kaveh Tashakori, son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 Durial 2 Cremation 32 Removal from State National Memorial 4 Dopation 5 Dother (Specify) 01/22/2011 Falls Church, Virginia vature of Fundral Service Liu nsee 22. Name and Address of Facility National Funeral Home 7482 Lee Highway, Falls MO1255 Church, Virginia Lee ghway. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ a Hypoxic Brain Injury disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or linjury the Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Records, P.O. Box 68760 the for use as 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 menths?
1 Yes 2 No Month Day Year 5 Other (specify) Pregnant at time of death signed by the a g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available 24a. Was an has autopsy prior to completion of cause of death? page 2 within 24 hours after death.

To the Funeral Director: After this certificate 1 Yes 2 No Yes 2 No 25. Was case referred to edical examiner? **Division of Vital** ted filled in by the funeral director, 26. Place of Death (Check only one) Be 2 No Hospital Other: ၉ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred Natural injury 5 Pending 2 Accident
3 Suicide Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29c. License number 6 6 2-6 C/ 29b. Signature and the of certifier 29d. Date signed (Month, Day, Year) ٩ 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Babak Pirouz, MD, 8600 Old Georgetown Road, Bethesda, Maryland 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 20 Registrar

Registrar
DHMH 17 Rev 7/2009

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 1.40A M ari hrashe Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Allaganu Draceline 3ex 1 M 2 F 9. Birthplace (State or Foreign Age (In yrs. last birthday) 8. Date of Birth Funeral Country) Maryland Months (Month, Day, Year) March 12, 1932 232-48-1737 78 Director Usual Residence of Decedent shov 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must be notified at Funeral Director 1 Yes 2 No Maryland Lonaconing Allegany 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21539 57 Jackson Street Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates White 3 ₩ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Home Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Mildred Grandstaff Joseph Kight 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15708 Warnick Road S.W., Frostburg, Maryland, 21532 Mary Margaret Brant - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pebruary 02 1 A Burial 2 Cremation 3 Removal from State Frostburg, Maryland Frostburg Memorial Park 2011 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Eichhorn-McKenzie Funeral Home P.A Brand Willelm 8 East Main Street Lonaconing, MD 21539 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician HRUNI disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Physician/Medical Examiner this to for as a nonsequence of Hospital or Attending Physician; The law requires that the death certificate be executed the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician Division of Vital Records, P.O. Box 68760 use as 1 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No for 5 Other (specify) Pregnant at time of death 4 ☐ Pregnant 9 ☐ Unknown signed by the at d be detached for 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy After this certificate has page 2 funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) e e examiner? Hospital 2 No 1 🗌 Yes Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at / work? 1 ☐ Yes 2 ☐ No Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred iniury Natural 5 Pending 24 hours after death. Funeral Director: A Accident Investigation 6 Could not be 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by determined City or Town, State) Medical 👺 certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check within 2 only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 02690 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) laish Red, Cumberland, Mari

DHMH 17 Rev 7/2009

State Registrar 32. Registrar's Signature

Day, Year) 0 4 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month January 19, Physician/ 2011 12:250M Frances Lee-Hwa Yen Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Shady Grove Adventist Hospital Rockville Montgomery Birthplace (State or Foreign Country) Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🎗 F Months Days 1073777939 Taiwan 417-66-6821 71 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 72 hours after death with the Maryland Director notified Rockville 1 Yes 2 No Maryland Montgomery 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ed other than "natural", or items 23a or event, the Medical Examiner must be a Funeral 20850 u.s.A. 804 Grand Champion Drive, Apt. #201 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. 1 Yes 2 X No If Yes, Give þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Completed 3 X Widowed 4 Divorced Asian Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Telecommunication Quality Assurance Engineer Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic en once. ൧ Jin-Shi Lee Yueh-Shia Yang 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Jennifer Y. Lee - Daughter 1420 N St., NW, Apt. #915, Washington, DC 20005 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 🔀 Burial 2 🗆 Cremation 3 🗖 Removal from State 01/22/2011 Rockville, Maryland 5 Other (Specify) Parklawn Mem. Park uneral Service 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 21. Signatury of M00709 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cardiac Physician/ Medical Due to (or as a consequence of): Examiner acute respiratory Sequentially list conditions. Due to (or as a consequence of): Examine it any, leading to immediate cause. Enter Underlying metas tatic uterine cancer attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 № No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has ; page 2 s autopsy performed? 1 ☐ Yes 2 🛣 No 1 Yes 2 No within 24 hours a er death.

To the Funeral Director: After this certific completed filled by the fune all director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 ☐ Yes 2 🗹 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 🗹 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide Investigation 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 1 Xcertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) DO64478 Melan January 19,

State Registrar 31. Date filed (Month, Day, Year)

JAN 21

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Fischatsion Mehan, MD 9901 Medical Center Drive, Rockville, manyland 20850

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Physician	n/	<ol> <li>Decedent's Name (First, Middle,La</li> </ol>						_ N	Date of Death Month	Day Year	3	Time of Death  0840 hrs	
Medical Examine			arcos Diaz Va	asque		Town o	r Location of		anuary 8,	2011 4c. County of D	eath		
17		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Washington Adventist Hospital Takoma Park							Montgomery				
Funeral		5. Social Security Number 6. S	ex 7. Age (In )	yrs. last b		der 1 Ye				10	. Birthp oreign	lace (State or	
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the Ma	Director	7910 15th Ave.			2	20783	3			Guatema	ala	/	
with a with be no	e a	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S.	13. Was Deced	dent of H	ispanic Origin n, Mexican, F	n? ( Specifi Puerto Rica	Yes or No-	14. Race - A White, e		n Indian, Black,	
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MD d 2 sha lth and n 27 in		Miguel Diaz Vaso								Md. 2078		State	
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be exe be urial -	흥	UNPENDED	AMENDED										
Box 68760, c death certificate b the attending physic deforuse as the bu	M	IF FEMALE: 3b. Was decedent pregnant in the	23c. If yes, outcome of	pregnan	cy 2 Fetal deat	h 3	Ectopic	pregnancy		23d. Date of de Month	livery Da	y Year	
X 68 th cert ttendin r use a	icia	past 12 months?  1 Yes 2 No 9 Unknow	4 Pregnant at time	of death	5 Other (Sp								
. Bo	Physician/Medical E	Part II. Other significant conditions	9 Ouknown	not resul	ting in the underlying	na cause	given in Par	t I.	23e. Did tob	acco use contribu	te to th	e cause of death?	
Division of Vital Records, P.O. rat or Attending Physician: The law requires that the safter death.  The Director: After this certificate has been signed by led in by the funeral director, page 2 should be detacted in by the funeral director, page 2 should be detacted.	<b>室</b>	Ture in Out of Significant Contains	CONTRIBUTING TO GOGG! Date				<b>3</b>		1 Yes	2 No 3	Probal	oly 4 Unknown	
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Vita	밁	1 <b>✓</b> Yes 2 No				DOA					Other:		
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Div ital or urs after illed in	Certification:	3 Suicide 6 Could no determine		g Lot				143	or Town, Sta O University	ate) / Blvd, Langley l	Park, I	MD	
	Medical C	29a. Certifier 1 Certifying Physic (Check only one) 2 Medical Examine	cian: To the best of my kno	wledge, tion and/o	death occurred at the control of the	he time, o my opinio	date and place on, death occ	ce, and due curred at the	to the cause time, date a	(s) and manner as nd place, and due	stated to the	cause(s)	
To To Com	Mec	29b. Signature and title of certifier	and manner stated.		2	9c. Licer	se number		I	29d. Date signed	(Monti	n, Day, Year)	
02		un au.	V.			0.0	.M.E.			January 9, 20	011		
		30. Name and address of person who	completed cause of death			eet Ro	ltimore M	MD 2122	3				
Sta	ate	Ling Li, MD Assistant N 31. Date filed (Month, Day, Year)	//edical Examiner \$			cci, Da	itiliore, IV	2122					
Registr		JAN 20 201	1 Dennes	do A	postal								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/  $0^{\text{Month}}$ 16 16 1:10 P M Anne Orr Weinberg Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Summerville Assisted Living Westminster Carroll Social Security Numbe 6 Sex If Under 1 Year If Under 24 Hrs 8. Date of Birth 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** Days 1 M 2 90 Months Hours Min. Country) 1917 91920 **Director** 232-26-5710 Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Carroll 1 XXYes 2 No Westminster 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? Funeral 45 Washington Road 21157 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes ※※ No Black, White, etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give 1 Yes XX No Specify Specify: White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) / Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) should be filed with and Mental Hygien ris marked other th 12 Homemaker Own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frank Orr Mae Stewart and 2 should b Health and Mer tem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Harold Weinberg/husband 45 Washington Road, Westminster, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a Department of H Important: If ite any injury or ot 1 ☐ Burial XXX Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/19/2011 Carroll Cremation Hampstead, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Pritts Funeral Home & Chapel Afarle 412 Washington Road, Westminster, MD 21157 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ement Medical resulting in death) Due to (or as a consequence of) Examiner month Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury wonard that initiated events Due to (or as a consequence of) resulting in death) Last burialphysician s the burial Physician/Medical fension Box 68760 SS IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Pregnant at time of death Month Dav Year 1 Yes 2 b the ed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ or Attending Physician: The law requires Records, 1 Yes 2 No 3 Probably 4 Unknown Osteo poroso Completed Marulan Degeneration 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy performed? Yes 2 No death? certificate 2 🗆 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this funeral 28a. Date of injury (Month, Day, Year) Death او 27. Manner Certificate: 28h Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 24 hours after death. Funeral Director: Al 2 Accident
3 Suicide
4 Homicide 1 Tyes Investigation 2 | No Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed To the I within 2. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) eariles MID 10061558 9/1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Westminster MD 21157 295 Ste 305 PARIKU STONER PALLUNI 31. Date filed (Month, Day, Year, 32/Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

JAN 19

P.O.

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 3:44 PM White Wangler 2011 JANUARY Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Lhester River Hospital hestertown Kent Center If Under 1 Year If Under 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 1 M 2 X OCT. Pay Year 1921 NEW YORK Hours 89 Director 085-18-3820 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Director CHESTERTOWN 1 X Yes 2 □ No MARYLAND KENT 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral USA 21620 466 HERON POINT within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married "natural", or þ Maryland 21215-0036 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates Specify. Specify: WHITE 3X☐ Widowed 4 ☐ Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important, If item 27 is marked other than "any injury or other traumatic event, the Mer Elementary/Seconday (0-12) College (1-4 or 5+) 12 HOMEMAKER OWN HOME Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ MARGUERITE JAMES ALBERT MC CREARY WANGLER 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17509 SOPER ST. POOLESVILLE, MD 20837 MICHAEL H. WHITE/ SON Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State STEVENSVILLE, MD JAN 14, 2011 CHESAPEAKE CNTR. 4  $\square$  Donation 5  $\square$  Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN, NEWNAM FUNERAL HOME that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Opset and Death Part 1. Enter the disease, or complications shock, or heart failure. List only one cause Immediate Cause (Final Physician/ GASTROINTESTINAL HEMORIZHAGE ACUTE disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Due to (or as a consequence of). if any, leading to immediate cause. Enter Underlying physician and the burial-transit Cause (Disease or linjury that initiated events The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 attending pl IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Live Birth 2 🗆 Fetal death in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) Pregnant at time of death cate has been signed by the page 2 should be detached 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ AND LUNG MALIGNANCIES 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown Records, Completed PULMONARY DISEASE 24b. Were autopsy findings available CHRONIC OBSTRUCTIVE 24a. Was an autopsy performed? Yes 2 No prior to completion of cause of death? To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, pagr 1 Yes 2 No **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA မ 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) 1 Natural work? 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 3 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 2011 3Q. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, 32. Registrar's Signature State JAN 18 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year 1:50PM **Physician** JANUARY 6, 2011 MARY ELLEN WILLIAMS /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner KENT CHESTERTOWN HERON POINT Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours 1 □ M 2X F MICHIGAN 11/06/1924 87 Director 362-24-1420 Usual Residence of Decedent e filed within 72 hours after death with the Maryland al Hygiene. other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State 77 is marked other than "natural", or items 23a or 28a-f shor traumatic event, the Medical Examiner must be notified at 1 XYes 2 No Director CHESTERTOWN KENT MD 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number UNITED STATES 21620 313 HERON POINT Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Yes 2 If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 🛣No Baltimore, Maryland 21215-0036 Specify: Specify: و م 3X Widowed 4 □ Divorced WHITE Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) **EDUCATION** COLLEGE SPEECH CONSULTANT 5+ 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be I and 2 should be fi Health and Mental F Is marked RUTH BOWEN ၉ JOHN L. SMITH 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 213 RICHARD DRIVE CHESTERTOWN, MARYLAND 21620 f Health LANCE WILLIAMS / SON 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Pages 1 20a. Method of Disposition permit. Pages
Department of
Important: if It
any injury or o ō 1 ☐ Burial 2 【X remation 3 ☐ Removal from State CHESTER, MARYLAND CHESAPEAKE CREMATION 01/07/2011 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Funeral Service L 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, 130 SPEÉR ROAD CHESTERTOWN, MARYLAND 21620 Approximate Interval Between Onset and Death death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Immediate Cause (Final EMEBROVASCULAR ACCIDENT Zweeks **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner 2 weeks THAL FIBRILLATION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner requires that the death certificate be executed and burial-tra Due to (or as a consequence of): resulting in death) Last physician Completed by Physician/Medical the as IF FEMALE: use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month in the past 12 months?

1 Yes 2 No
9 Unknown Day 5 Other (specify) P.0. signed by the a I be detached f þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Physician; The law autopsy page 2 1 ☐Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To this 28a. Date of Injury (Month, Day, Year) within 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral in the fun 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Injury Division or Attending Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie D0041587 7-2011

State Registrar 30. Name and address of person

31. Date filed (Month, Day,

pleted cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene #19A 01/07/11, TM Kent CO Certificate of Death Amend Item Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death WARREN EDITH Month Year Physician/ DRENCE 4:00 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County, of Death **Examiner** Johnson Avenue Ha 0 Birthplace (State or Foreign Country)
 MD 8. Date of Birth (Month, Day 3ear)192 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Funeral Days 1 □ M 2 🄀 F Months Hours Min. 90 **Director** 20-03-4454 Usual Residence of Decedent show 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 72 hours after death with the Maryland "natural", or items 23a or 28a-f sho Director Rock Hall MD Kent 1 🗆 Yes 2 🖾 No 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 21661 22111 Johnson Avenue Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12, Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. 1 ♣ Never Married 2 ☐ Married δ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 H No Specify: Specify: Black If Yes, Give 3 Divorced Completed Year or Dates Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 h. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, the Medicone. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Sewing Factory Folded shirts 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Melvin William Warren Ivory Geneva Thompson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22111 Johnson Avenue Rock Hall, MD 21661 19a. Informant's Name/Relationship (Type, Print) Gary Teat Son Garry 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date Aarons Chapel Cemetery 1/15/11 Rock Hall, MD cemetery, crematory or other place) 1 🖾 Buríal 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) 22. Name and Address of Facility 21, Signature of Funeral Service License <sup>22. Name and Address of Facility</sup> Bennie Smith Funeral Home 855 High Street Chestertown, MD 21620 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Immediate Cause (Final BREAST CANCER, METASTATIC year Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to in recipitate cause. Enter Underlying Examiner Due to for as a consequence of The law requires that the death certificate be executed Cause (Disease or linjury the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical P.O. Box 68760 use as 1 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Pregnant at time of death signed by the at d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28h Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier D004158 1-4-2011 who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Yea

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 01 1.8 2011 2:55p Leon Wynter Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Casey House
5. Social Security Number 16.5 Rockville Montgomery 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 XM 2 □ F Months Hours Min Month, Day, Yes Director 57 <u>Bronx,NY</u> 084-44-2302 Usual Residence of Deceden ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Director 1x Yes 2 No Silver Spring Maryland Montgomery 10f. Zip Code 10e. Street and Numbe 10g. Citizen of What Country? Funeral 9300 Sutton Place 20910 "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2X No If Yes, Give þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify. Specify. 3 Widowed 4 Divorced Completed Black Year or Dates 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)
Communication Medical 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) id Mental Hygiene. marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) the Masters Government Director traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) . Page 1 and 2 should be fill iment of Health and Mental tant: If item 27 is marked ပ Wynter Rupert Svlvia Juredini 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9300 Sutton Place, Silver Spring MD 20910 Karen Brown - Ex-Wife 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of IImportant: If ite
any injury or ot 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Woodlawn Cem. 1-26-2011 Bronx, NY 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Adams Funeral Home Pa, Aquasco MD 20608 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Multiforme Glioblastoma Physician/ 448900 # Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): physician and the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical that the death certificate be 68760 attending p IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery Box Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year Day Pregnant at time of death 5 Other (specify) sate has been signed by the page 2 should be detached 9 Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 📈 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 1 ☐ Yes 2 🛣 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical of Vital Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 D Other (Specify) Hupice 2 No 2 1 Inpatient 2 ER/Outpatient 3 I 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: or Attending 1 Natural 5 Pending Division 1 Yes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 1-18-2011 30. Name and address of person completed cause of death (Item 23a) (Type, Print) Mill Rd, Rockulle Muncaster NB 12 6001

Registrar

State

Registrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Bobbie Jean Webb January 18, 2011 11:35 a<sup>M</sup> Medical 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Examiner 6797 Amherst Road Bryans Road Charles 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 😾 F Months Days Hours Min. July 26, 1938 North Carolina 73 Director 245-54-1589 Usual Residence of Decedent show 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10c. City. Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f sho Director 1 Yes 2 No Maryland Charles Bryans Road 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 20616 6797 Amherst Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 X Married Saltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 😾 No Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Her Home and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Sally Hall James Lamn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important; If item 27 is any injury or other trau once. Md. 20616 6797 Amherst Rd., Bryans Road, Ronald Webb Husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 

Burial 2 □ Cremation 3 □ Removal from State cemetery, crematory or other placean 4 ☐ Donation 5 ☐ Other (Specify) Trinity Memorial Gardens Waldorf, Maryland 22. Name and Address of Facility
Williams Funeral Home, P.A. 21. Signature of Funeral Service Lice M00668 Indian Head. 4270 Hawthorne Rd., disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, failure. List only one cause on each line. 23a. Part 1. Enter th shock, or hear Immediate Cause (Final Onset and Death Pnysician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine as a consequence of, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this confliction has been also as a confliction of the second of the ate has been signed by the attending physician and page 2 should be detached for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Year Day Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ 2 No 3 Probably 4 Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? To the Funeral Director: After this certificate I completed filled in by the funeral director, pag 1 Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 2 No 1 Tes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 
Nursing Home Certificate: To 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 🗌 Yes 2 No Investigation Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) DO05409 9/2011

72158

State Registrar Linda M

Jefferson

2670 Crain Hwy., Suit 410, Waldorf, Md. 20601

onpleted cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

M.D

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 14, Day 2011 Year Gladys H. Welty Jannth . Physician/ 5:30 A M Medical 4a. Facility Name (if not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 305 Catoctin Avenue Frederick Frederick 5. Social Security Number 217-16-5214 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign **Funeral** 1 □ M 2 🏋 F Hours Year 1911 Mary Tand Director Usual Residence of Decedent 28a-f shov 10h County 10c. City, Town or Location 10a. State 10d. Inside City Limits the Medical Examiner must be notified at Director MD Frederick Frederick 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 23a or Funeral 305 Catoctin Avenue 21701 United States "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🎇 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: If Yes Give Specify: White 3 Nidowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business Industry if Health and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Tolbart K. Houck, Sr. Nora A. S. Haugh should be 19a. Informant's Name/Relationship (Type, Print)
Frank H. Welty / Son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 305 Catoctin Ave., Frederick, MD 21701 20a. Method of Disposition
1 ⚠ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of January 22, 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important; If ite
any injury or ot Mt. Olivet Cemetery Frederick, Maryland 4 Donation 5 Other (Specify) 2011 22. Name and Address of Facility Reeney & Fastord P.A. Funeral 21. Signature of Funeral Service Licer M01433 106 E. Church St., Frederick, MD 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final CARDIOMYOPATH Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examir ng physician and as the burial-transit that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: es, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Dav Pregnant at time of death 5 Other (specify) Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ To the Hospital or Attending Physician: The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗗 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed æ 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗌 only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 221936 one Iron 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FREDGRICK, MD Z1702 VO4NOON A. WINELSON, MI 65C THOMAS 31. Date filed (Month, Day, Year) 32. Registrar's Signat State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 201 GERTRUDE WATKINS 4:45 HELEN AM Jan. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Forest Hill Harford Rock Spring Village If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) May 10, 1 Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 F Months Virginia **Director** 219-22-3718 83 Usual Residence of Decedent or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits should be filed within 72 hours after death with the Maryland other traumatic event, the Medical Examiner must be notified at Director 1 🗌 Yes 2 💢 No MD. Harford Forest Hill 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21050 2415 Minnick Drive United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No permit. Page 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or i any injury or other traumatic event, the Market. ρ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give 3 ₩ Widowed 4 □ Divorced Specify: White Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Housewife Home unknown Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Horecka Kratochvil Antonia 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21161 White Hall, MD. (Son) 5136 Meadowstream Garth Charles E. Watkins 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Jan Date 27 1 A Burial 2 Cremation 3 Removal from State Donation 5 Other (Specify) Air Mem. Gardens 2011 Bel Air, Maryland 21. Signature of Funeral Service 22. Name and Address of Facility E.G. Kurtz & Son Funeral Home, Jarrettsville, Maryland 23a. Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician, disease or condition resulting in death) Medical ue to (o as a consequence or **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to ( as Exami Hospital or Attending Physician: The law requires that the death certificate be executed 4/2 attending physician and for use as the burial-tran that initiated events Due to (or as resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregna 23d. Date of delivery 3 Ectopic pregnancy in the past 12 month Month Pregnant at time of death 5 Other (specify) the g 🗌 Unknown g Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> Completed 1 Yes 2 No 3 Probably 4 L Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perform Yes 2 certificate 1 Tyes 2 🔄 No 25. Was case referred to medical B B 26. Place of Death (Meck only one) examiner? 2 No 2 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 IDOA within 24 hours after death.

To the Funeral Director; After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred | Aatural 5 Pending 1 Yes 2 No Investigation 6 Could not be Accident Suicide
Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

FEB 04

рМ

Year

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Jan. 19,

2011

MD 20910

Registrar DHMH 17 Rev 7/2009

State

lospital 24 hours Medical

29a. Certifier

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Majid Raymanian,

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D66372

1500 Forest Glen Road, Silver Spring,

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Unian

22. Registrar's Signature

determined

nm

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1 Decedent's Name (First Middle | ast) 2. Date of Death Physician/ AMIA SAKINAH Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE 1120 MIRGA CIRCLE GWYNN OAK Social Security Number 6 Sex 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗓 F Hours 11-16-1943 MARYLAND Director 212-44-6184 67 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 X Yes 2 ☐ No BALTIMORE GWYNN OAK 10e. Street and Number 10f. Zip Code 23a or 10a. Citizen of What Country? Funeral 1120 MIRGA CIRCLE 21207 USA Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 14. Race - American Indian. Armed Forces?,
1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married or. Completed by 21215-0036 1 Yes 2 No Specify: If Yes, Give Specify: BLACK "natural" 3 Widowed 4 XDivorced Year or Dates is marked other than "natur aumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16h, Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) -12-OPERATING ROOM TECH UNION MEMORIAL HOSPITAL Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ပ JAMES HARRIS FRANCES RODGERS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 29642 Department of Health a Important: If item 27 is any injury or other tra JACQUELINE SHOEBROOK (SISTER) 412 SPIRIT MOUNTAIN LANE EASLEY, SOUTH CAROLINA 20a. Method of Disp6 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) ☐ dremation 3 ☐ Removal from State MARYLAND NATIONAL 2-8-2011 LAUREL, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) HIBNER, Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. Signature 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Fi Cause (Final Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) ig physician and as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year been signed by the should be detached Unknown g 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy cate has page 2 s performe 2 🗌 No Yes 2 N 1 🗌 Yes Division of Vital 25. Was case referred to medical funeral director. Be 26. Place of Death (Check only one) examiner? Hospital: 2 1 Tyes 2 2 No Other: 1 Inpatient 2 ER/Outpatient 3 I 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of s after death. Certificate: 28c. Injury at work? I or Attending P after death. 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 Yes 2 🗌 No Investigation ☐ Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4  $\square$  Homicide determined Hospital 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifies To the within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certific

Stat

State Registrar Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Day Physician/ Month Lorraine Allen D 13:55 Feb 2011 Medical 4a, Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Burnie Anne Glen Arundel Baltimore Washington Medical Center If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 6. Sex 7. Age (In vrs. last birthday) Social Security Number **Funeral** Days Min (Month, Day, Year) 03-06-1938 New York 1 M 2 X F Director 72 069-30-3518 Usual Residence of Decedent If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 10b. County 10d Inside City Limits 10a. State 10c. City, Town or Location Director 1 ☐ Yes 2 😾 No Anne Arundel Odenton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 610 Rita Drive 21113 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Yes 2 X No 1 Never Married 2 X Married þ 1 ☐ Yes 2 X No Specify: d Mental Hygiene. marked other than "natural", 3 Widowed 4 Divorced <sup>Specify</sup> African American Completed Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Mental Health Technician D.C. Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be filed of Health and Mental Health and Mental Health and Mental Health and New 1 is marked of ပ္ Sarah E. Salters Delaney M. Norman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard Allen, Sr. / Husband Rita Drive Odenton, Maryland 21113 20b. Place of Disposition (Name of cemetery, crematory or other place)
Lakemont
Memorial Gardens 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 02-09-2011 Davidsonville, MD 21. Signature of Funeral Service License 22. Name and Address of Facility
Donaldson Funeral Home & Crematory, P.A.
1411 Annapolis Road Odenton, Maryland 21113 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Coronary artery disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): physician and the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical attending ph IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year Month 5 Other (specify) Pregnant at time of death 1 Yes 2 5 Yes 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☒ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed certificate 1 Ves 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Yes 2 ☐ No 1 Inpatient 2 KER/Outpatient 3 IDOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After to completed filled in by the funeral To the Hospital or Attending 1 Natural 5 Pending 1 🗆 Yes 2  $\square$  No 2 Accident
3 Suicide
4 Homicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) February 1, 2011 M D67721

Registrar

State

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

RO1 #104

Annapolis

Odenton MD 21113

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BHATIA

31. Date filed (Month, Day, Year)

FEB 0 7 2011

1132

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Year egraty Medical City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner KAVEN LC IMUR 8. Date of Birth (Month, Day, 0 2 / 2 3 / Birthplace (State or Foreign Country)
 MD If Under 1 Year If Under 24 Hrs. (In yrs. last birthday, **Funeral** 215-22-9892 83 Months Days Hours Min. 1 🔀 M 2 🗆 F Director Usual Residence of Decedent or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturol" any injury or other traumatic event. 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Director MD Baltimore M☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3528 Elmore Avenue 21213 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 ☐ No Black, White, etc. 1 Never Married 2 Married ð Specify: White 1 Yes 2 No Specify. If Yes. Give 3 Divorced 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 6 Maintenance Painter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Marvin Ashburn Marie Ehm 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 6103 Cardiff Avenue, Baltimore, MD Maryanna Evering/Cousin 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)

Final Journey Crem. 1 🗆 Burial 2 🕮 Cremation 3 🗆 Removal from State 2/5/2011 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Maryland Cremation Services
PO box 1413, Baltimore, MD21203 . Signature of Funeral Service Licensee Borota Marshall 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as hsequence of) Examiner Sequentially list conditione, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transi that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 \( \subseteq \text{ Yes} \quad 2 \subseteq \text{ No} \) Month Day 5 Other (specify) Pregnant at time of death 1 Yes 2 9 Unknown Unknown P.O. by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 1 X Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an has autopsy performe certificate 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this Manner of Dath 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at eral Director; After filled in by the funer work 5 Pending hours after death. 2 🗌 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier mpleted cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year State FEB Registrar

H DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January 2011 11:05 P M David Lee Bosse Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel 7658 Porcelain Tile Court 0denton If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. . Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🛛 M 2 🗆 F (Month, Day, Year) 08-21-1945 Virginia Months **Director** 220-40-3925 65 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he material once. I Hygiene. I other than "natural", or items 23a or 28a-f shov vent, the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director 1 🗌 Yes 2 💢 No MD Anne Arundel Odenton 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 7658 Porcelain Tile Court <u>United States</u> 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. Race - American Indian. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. ģ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: Completed 3 Widowed 4 Divorced White Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Heating Ventilation and Air Conditioning Mechanical Engineer 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Virginia Mae Dumdey Francis Xavier Bosse 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7658 Porcelain Tile Court Odenton, Maryland 21113 Patricia Marshall Bosse / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Durial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Arundel Crematory 02-06-2011 Odenton, Maryland 21. Signature of Funeral Service 22 Name and Address of Facility
Donaldson Funeral Home & Crematory, P.A Well & Some 1411 Annapolis Road Odenton, Maryland 21113 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Pnysician/ ROSARCOM disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease of Injury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Dav Pregnant at time of death 9 Unknown Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Division of Vital Records, 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 D(No ၉ 1 🗌 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after occur...

To the Funeral Director: After this 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred work?
1 Yes 2 No Natural 5 Pending 2 Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in this opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Negree Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier

Registrar
DHMH 17 Rev 7/2009

State

O/

31. Date filed (Month, Day, Year)

and address of person who completed cause of death (Item 23a) (Type, Print)

en M

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registra 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February Bagdasar 2011 10:04  $A^{M}$ Bakirci Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery 5. Social Security Number 8. Date of Birth (Month, Day, Year) January 1, I 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F Months Hours Turkey **Director** 214-23-2881 89 Ĩ922 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Direct Maryland Montgomery Silver Spring 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13006 Carney Street 20906 United States death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. 1 Never Married 2 X Married \$ ☐ Yes 2 🕅 No Baltimore, Maryland 21215-0036 72 hours after 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) filed within 72 all Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Mechanic Automotive Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, should be file and Mental F is marked of Karabet Bakirci Maran (unk) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 Zaven Bakirci / Son 13006 Carney Street, Silver Spring, Maryland 20906 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Silver Spring, February permit. Page 1 Department of Important: If it any injury or o ō X Burial 2 Cremation 3 Removal from State Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 7, 2011 Maryland 21. Signature of Funeral Service Lisensee 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 ingelette man M01305 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph sician/ disease or condition resulting in death) Respiratory Failure Medical Due to (or as a consequence of) Examiner Sepsis Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): and I-transit requires that the death certificate be executed Cause (Disease or iinjury Urinary Tract Infection that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Live Birth 2 Fetal death in the past 12 months? 5 Other (specify) Pregnant at time of death Month Day Year 2 No ed by the a 9 Unknown 9 🗌 Unknown s been signed to should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Dementia, Atrial Fibrillation, Thrombocytopenia 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Hospital or Attending Physician: The law page 2 s has performe After this certificate funeral director, pag 1 ☐ Yes 2 ☐ No 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 💹 No ၉ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 🗌 Pending (Month, Day, Year) work' 24 hours after death.

Funeral Director A 1 🗌 Yes 2 🗌 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical 29a. Certifier X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check within 2 the only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0968164

State Registrar

DHMH 17 Rev 7/2009

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32. Registrar's Signature

8600 Old Georgetown Road, Bethesda, Maryland 20814

30. Name and address of person who completed asse of death (Item 23a) (Type, Print)

Kimberly B. Zurak, MD

31. Date filed (Month, Day, Year)

FEB 0 7 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month February 2011 2011 3:30 P M Jean Berthold Brewer Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Suburban Hospital Bethesda Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min. 1 M 2 X F October 10, 1925 Pennsylvania 85 Months Hours **Director** 201-14-7566 Usual Residence of Decedent show 10b. County "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 K No Maryland | Montgomery Rockville 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4802 Listra Road 20853 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian Armed Force Completed by 1 Never Married 2 Married Yes 2 X No 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White If Yes, Give 3 Widowed 4 Divorced Year or Dates Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natu
any injury or other traumatic event, the Medical
one. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Montgomery County Elementary/Seconday (0-12) College (1-4 or 5+) Administrative Assistant Public School Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Joseph Berthold Beatrice Kiralfy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John J. Brewer/Husband 4802 Listra Road, Rockville, Maryland 20853 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Page 1 cemetery, crematory or other place)
Montgomery
Crematorium, Inc. February 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bethesda, Maryland 6. 2011 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850 (myelatta) M01305 monu 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition Intracranial Hemorrhace Medical resulting in death) Due to (or as a consequence of): Examiner F<u>a</u>1 6 hours Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to (or as a consequenc 1 of) death 02/01/2011 as the burial-transi and Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical 2 Hospital or Attending Physician: The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ To the Funeral Lifrector: After his certificate has been signed by the attencompleted filled in by the funeral director, page 2 should be detached for it in the past 12 months? Month Pregnant at time of death 4 ☐ Pregnant : 9 ☐ Unknown Yes 2 X No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Records, 1 ☐ Yes 2 K No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an 1 Yes 2 No Yes 2 X No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 1 X Yes 2 ☐ No Medical Certificate: To 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Division of 28c. Injury at work? 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Natural 5 Pending iniury 2 X Accident February 1, 2011 1 ☐ Yes 2 🖾 No Slip and Fall Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)
Home 28f. Location (Street and Number or Rural Route Number of City or Town, State) if 602 1,572 Rd 4 Homicide determined m10 2055 24 hours 29a. Certifier X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number he chher, My D66414 2/3/(( 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) O V Greenwa 0. Ste 309, Greenselt, 31. Date filed (Month, Day, Year) FEB 07 2011 Registrar

EXAMINE

MEDICAL

DELEASED

Math 3: 40PM

EWER

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND #30 PER DVR G912 2/07/2011 JH
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** BIENES 12:32 PM ERNA JANUARY 23 2011 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Harford Bel Air Autum Assisted Living If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Ye April 14, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Year 1923 **Funeral** Months 1 □ M 2 🖾 F Austria 87 Director 578-50-1928 Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County show r 28a-f show notified at 1 ☐ Yes 21K No Director Harford Harve de Grace 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ms 23a or must be r death with USA 21078 4125 Webster Road Funeral iral", or items ? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X No 14. Race - American Indian 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after and Health and Mental Hygiene. 1 ☐ Yes 2X If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 white 1 ☐ Yes 2 ☒ No þ Specify: Specify: 3 Widowed 4 □ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 7 is marked other than "natu traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) healthcare nurse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Franz Peer Maria Petelin မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jerry Bienes - son 122 Bath Circle; Washington, NC 27889 Health tem 27 other t 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If Ite any Injury or ot once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) Funeral S ROHAL 22. Name and Address of Facility State Anatomy Board Director 655 W. Baltimore St; Baltimore, MD 21201 23a. Partt. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoot, or heart failure. List only one cause on each line.

Immediate Course (Final disease or condition resulting in death)

a. METASTASIS TO BONE BRAIT Approximate Interval Between Onset and Death Physician 3mon TMS /Medical Due to (or as a consequence of): Examiner LUNG Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner The law requires that the death certificate be executed the burial-transi Due to (or as a consequence of) Box 68760, physician for use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) Division or Vital Records, P.O. cate has been signed by the a page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 Probably 4 Unknown ARTER 4 OPOMARY Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe certificate 2 1 No or Attending Physiclan: funeral director. 25. Was case referred to medical AUTUMN ASSISTED LNING. Place of Death (Check only one) Be Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA | Other: 4 | Nursing Home 5 | Residence 6 | Other (Specify) 1 Yes 2 No Certification: To After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death Natural 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation Injury To the nosposate death.

Within 24 hours after death.

To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide Hospital 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only the 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) JAN. 25, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AUTUMN ASSISTED LIVING BEL AIR, MD 21078 ANURAAC SOOD 31. Date filed (Month, Day, Year). 32 Pegistrar's Signature State

Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month O 1 15:53 Anita L. Bennett 201 30 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Good Samaritan Hospital Baltimore MD 5. Social Security Number 8. Date of Birth (Month, Day, Year) Oct 3, 1933 Funeral 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 1 M 2 E Hours Min. Maryland Director 212-30-4259 Usual Residence of Decedent or 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? **Funeral** 1325 Glendale Rd 21239 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc. white 1 Never Married 2 Married Completed by 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 ▼ Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 0 interviewer market research Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Myrtle Lighthiser John McIntyre Logan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) W. 37th St; Baltimore, MD 21211 <u> Lisa Brawner - daughter</u> 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) 21. Signatu e o juner provice Licent, e 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final of Mysician, xic 10 disease or condition hours Medical resulting in death) Examiner Socientially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death
Unknown ate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed After this certificate 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 No Other: 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, geath occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29c. License number 30,2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ba MC 32. Registrar's State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February 4, 2011 2:08PM M Geraldine Grace Clements Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 9105 Kilbride Road Baltimore Nottingham Social Security Number 9. Birthplace (State or Foreign Country) D A If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** June 30, 1 □ M 2 ⋤ F PA Director 181-30-6186 72 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits should be filed within 72 hours after death with the Maryland Director 1 Tes 2 No Baltimore Randallstown 10e. Street and Number 10g. Citizen of What Country? Funeral 3911 Rayton Road 21133 USA and Mental Hygiene. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Completed by 1 Never Married 2 Married 1 ☐ Yes 2 🌠 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 3 - Widowed 4 - Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Domestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Catherine Penkala Andrew Gido 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Spouse) .. Page 1 and 2 sl tment of Health a item 27 Mr. Joseph H. Clements, permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other th 3911 Rayton Road, Randallstown, MD 21133 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔀 Burial 2 □ Cremation 3 □ Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) Holy Family Cemetery 2/8/2011 Randallstown, MD 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PA 21. Signature of Funeral Service Licenses M00764 PO Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Metastatic Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 month 1 Yes 2 No 9 Unknown ate has been signed by the atte page 2 should be detached for Month Day Year Pregnant at time of death P. 0. Part II. **Other significant condition**s contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy of Vital within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 🗹 No Other: 1 Tes မ 4 Nursing Home 5 Residence 6 X Other (Specificaughter's home 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pendina Division 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Chec only o Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signatu and title of certifier 29d. Date signed (Month, Day, Year) D45390 February 7th 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Myo Min (h.D.) 9114 Philadelphia Road # 208, Baltimore 32. Registrar's Sig

Registrar
DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2011 FEBRUARY BERNICE C. COSKI 0912 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death CARROLL CARROLL COUNTY GENERAL HOSPITAL WESTMINSTER Social Security Number 8. Date of Birth Funeral 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Months Days Hours Min. 4/6/1924 MARYLAND 216-14-8161 Director Yrs. Usual Residence of Decedent 28a-f shov 10a. State 10b. County ıral", or items 23a or 28a-f sho Examiner must be notified at. 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director MD N/A BALTIMORE CITY X Yes 2 □ No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3618 ELMORA AVENUE 21213 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2X No Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2X No Specify: "natural" 3 Widowed 4X Divorced Specify: WHITE Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done life. DO NOT use retired) during most of working than within 7 Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. the ADMINISTRATIVE ASSISTANT 12TH GRADE INSURANCE æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be filk Department of Health and Mental I Important: If item 27 is marked of any injury or other traumatic eve ည JOHN COSKI MARY NOVAK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 473 SOUTH HILLS COURT WESTMINISTER, MD TERESA COSKI/GRANDDAUGHTER Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State MOST HOLY TREDEEMER 4 Donation 5 Other (Specify) 2/8/2011 BALTIMORE, MD CEMETERY 21. Signature of Funeral Service Licensee MOO21 22. Name and Address of Facility THE JOHNSON FUNERAL HOME. TOWSON, MD 8521 LOCH RAVEN BLVD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sev MANN YAS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury Examine Due to (or as a consequence of) the burial-transi the attending physician and hed for use as the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months 1 Yes 2 No 5 Other (specify) Month Dav Year 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DISANDER 1 Yes 2 10 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? C 52 BLAZ 24a. Was an within 24 hours after death.

To the Funeral Director, After this certificate has I completed filled in by the funeral director, page 2 s autopsy performed Yes 2 N 1 🗌 Yes å 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 <del>4 N</del>o Other: 욘 1 🗌 Yes 1 Impatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Pri

State Registrar Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Baltimore,	t. Page 1 tment of tant: If it ijury or o		1 Burial 2		B ☐ Removal from		cemetery, cremato		1-7	Date 3 / - / /	GRE	ocation - City or	DE M	9	
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f Vit	Physici this cer ral direc	၉	examiner? 1  Yes 2	No	Hospital: 1 28a. Date		ER/Outpatient 3	□ DOA Other: 4 [		ome 5 🗆 Resi		Other (Spec	ify)		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Edith Grace Chesnut February Day Physician/ 201 10:45am 3, Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
Baltimore Examiner Timonium Stella Maris Hospice If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 5. Social Security Number 212-30-6206 7. Age (In yrs, last birthday) 79 yrs **Funeral** 1 🗆 M 2 🕱 F Months Days Hours 077377 1931 Country) MD Director Usual Residence of Decedent Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location Director Baltimore Timonium MD 1 ☐ Yes 2X No 10f. Zip Code 21093 10g. Citizen of What Country? 10e. Street and Number 2300 Dulaney Valley Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married Completed by 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: White 3 ☐ Widowed 4 🎦 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Cafeteria Worker StellaMMaris Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Lilian LeCom Edward Joseph Griffin LeCompte မှ 19a. Informant's Name/Relationship (Type, Print)
Kimberly Ann Hoerr /Niece 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2216 Quail Creek Court, Bel Air, MD 21015 20b. Place of Disposition (Name of cemetery, crematory or other place)
Final Journey Crem. 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 2/5/2011 Woodbine, MD 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee Dorrota Marshall 22. Name and Address of Facility
Maryland Cremation
PO Box 1413, Baltin Services MD2 'ornele 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician a. NASAPHARYNGEAL CANCER disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury physician and the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): cate has been signed by the attending physician page 2 should be detached for use as the burial Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day Month Year Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 1 Tes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Director: After this certificate has autopsy perform 1 ☐ Yes 2 ☐ No completed filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Other: 1 Tes 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 X Other (Specify) HOSPICE 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending 1 🗌 Yes 2 🗌 No Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 🕱 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 29b. Signature and 29d. Date sighed (Month, Day, Year) s of person who completed cause of death (Item 23a) (Type, Print) 30. Name ang 2300 DULANEY VALLEY RD. MD 21093 JACKIE JONES, CRNP TIMONIUM, Registrar

10:54

FEBRUARY

CHESNUT

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND #10F PER FH G912 2/07/2011 JH State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ WALTER COHEN **FEBRUARY** 2011 4:00 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner COURTLAND GARDENS BALTIMORE BALTIMORE 8. Date of Birth (Month, Day, Year) . Age (In yrs. last birthday) 95 vre 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number **Funeral** 1 🛛 M 2 🗆 F Months Hours Min. MD **Director** 01/19/1916 213-09-7557 Usual Residence of Decedent f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD N/A BALTIMORE 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? AVENUE Funeral 5815 GREENSPRING 21209 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 X Yes 2 □ No Black, White, etc. ģ 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: If Yes. Give Specify: WHITE3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) SALES REAL ESTATE 10 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ **JACOB** COHEN IDA SIMON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5815 GREENSPRING AVENUE BALTIMORE, MD 21209 JACQUELINE COHEN / WIFE Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State BALTIMORE HEBREW CEM. 2/04/2011 4 Donation 5 Other (Specify) REISTERSTOWN, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. re of Funeral Serfice Livens 8900 REISTERSTOWN ROAD PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one Interval Between Onset and Death Immediate Cause (Final JROSEPSI) Physician/ disease or condition resulting in death) -1 week ) Medical Due to (or as a consequence of) Examiner FISTUla IMONTH 00-VESICULUA Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause ilinjury Due to (or as a consequence of) been signed by the attending physician and should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months? Month Year Day Pregnant at time of death 2 No 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate has completed filled in by the funeral director, page 2 performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 2 No Hospital: Other: 1 🗌 Yes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 Tyes 2 No Accident Investigation 24 hours after dea: Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one 29b. Signatur nd title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 25039 dresh of person who completed cause of death (Item 23a) (Type, Print)

Who Bours, MD W35 SMITH AVE BALTIME MD 21209 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

FEB 07

11-00399 Oscar Paul Dulaney 1- For State Certificate of Death Reg. No. 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day January 14, 2011 0638 hrs Medical Examiner Oscar Paul Dulaney 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Baltimore Mercy Hospital 5. Social Security Number 1 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or UNK 6. Sex **Funeral** Days Months Hours Director April 19, 1964 45 1X M 2 F 46 Country) MD Yrs 212-88-7192 Usual Residence of Decedent 10b. County-Unix 10c. City, Town or Location 10d. Inside City Limits 10a State 1 X Yes 2 No or 28a-f show MD Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. and: If item 27 is marked other than "natural", or items 23a or 28a-f sho are traumatic event, the Medical Examinary. Balto Middle River Director 10f. Zip Code -Unk 10g. Citizen of What Country? 10e. Street and Number 110 USA 64 Shawgo Ct 21220 12. Was Decedent Ever in U.S.
Armed Forces? Funeral 11. Marital Status Lunk 13. Was Decedent of Hispanic Ongin? (Specify Yes or No- Race - American Indian, Black. White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Never Married 2 X Married Yes Specify: white Yes, Give Year 4 Divorced 1 Yes 2X No specify: 3 Widowed 亥 16a. Decedent's Usual Occupation (Give kind of work done 117K) 16b. Kind of Business/Industry117K 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) **Baltimore, MD 21215-0036** -unk9 Carpenter Construction 18.Mother's Name (First, Middle, Maiden Surname)-UTH 17. Father's Name (First, Middle, Last) Oscar Paul Dulaney Be Linda Joyce Snyder (Street and Number or Rural Route Number, City or Town, State, Zip Code) ပ္ 193 Informant's Name/Relationship (Type, Print)
TammyDulaney/sister O.C.M.E. 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date crematory or other place) Burial 2 X Cremation 3 Removal from State permit Pages
Department o
Important: Donation 5 MOther Specify: in state Final 2/10/2011 Journey Woodbine MD Name an Address of Facility

rylandCremation State Anatomy Pour de Roy 1413

655 W. Baltimore St; Baltimore, MD 21. Si ature - Licenses Director Approximate Interval Part I. Enter the disease, or com death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart - Physician Between Onset and failur. List only one cause on each line. /Medical Death Alcohol and Chlordiazepoxide Intoxication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last attending physician and or use as the burial - tran sician/Medical x AMENDED 23a,27,28a-f per me g917 7-15-11 vt X UNPENDED or Attending Physician: The law requires that the death certificate be P.O. Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Month Day Year 1 Live birth 3 Ectopic pregnancy 2 Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown the Phy 23e. Did tobacco use contribute to the cause of death? signed by t. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I ⋧ 1 Yes 2 No 3 Probably 4 V Unknown Completed of Vital Records, 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has death? performed Yes 2 No 1 🗸 Yes 25. Was case referred to medical 26 Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 2 FR/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other this 2 No 1 Yes After Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification \_\_\_ Natural 1 Yes 2 X No fd 1-14-11 fd 6:04am Investigation Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 400blk of E. Fayet St. Baltimore, Md. 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide 6 X Could not be E. Fayette

Division within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) January 14, 2011

racks

O.C.M.E

unelet authout, MS 30. Name ay a dress of person who completed cause of death (Item 23a)

determined

900 W. Baltimore Street, Baltimore, MD 21223 Pameia E. Southall, MD Assistant Medical Examiner

street

State Registrar

Vanard Duperreault

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Unk Unk State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ 3. Time of Death Month Day January 7, 2011 Medical Examiner 1715 hrs Vanard Duperreault 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 2300 Washington Boulevard **Baltimore** 5. Social Security Numberunk 6. Sex 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or unk 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Director Months Min 58 Aug 18, 1952 1 X M 2 F Country) Yrs Usual Residence of Decedent 10a, State 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No Baltimore Director 10e Street and Number 10g. Citizen of What Country? 10f. Zip Code 2300 Washington Blvd 21230 USA Funeral 11 Manital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? unk If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married 2 Yes Specify: White 4 Divorced If Yes, Give Year or Dates: Yes 2 No specify: \$ 16a. Decedent's Usual Occupation (Give kind of work done U11k) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed within 72 l Department of Health and Mental Hygiene. Impurtant: If item 27 is marked after than ", injury ar other traumatic event, the Medical E College (1-4 or 5+) Baltimore, MD 21215-0036 unk unk 17. Father's Name (First, Middle, Last) UNK 18.Mother's Name (First, Middle, Maiden Surname) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 900 W. Baltimore St; Baltimore, MD 21223 O.C.M.E. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 X Other Specify: in state 21. Signature of Funer I Service Lice ROPALG 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval ailure. List only one cause on each line Between Onset and /Medical Death Cirrhosis of Liver Complicated by Hypothermia Immediate-Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed ned by the attending physician and detached for use as the burial - trans Physician/Medical AMENDED 23a, pt. II, 27, 28a-f per me g912 2-14-11 vt X UNPENDED Box 68760, IE FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Month Day Year 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≦ Chronic Alcoholism 1 Yes 2 No 3 Probably 4 ✓ Unknown Completed After this certificate has been funeral director, page 2 should 24b. Were autopsy findings available 24a, Was an prior to completion of cause of performed death? ✓ Yes 2 No 1 🗸 Yes 2 No the Hospital or Attending Physician: hin 24 hours after death. 25. Was case referred to medical 26.Place of Death (Check only one) å examiner? Hospital: 1 Inpatient 2 Other Nursing Home 5 Residence 6 🗸 Other: Scene FR/Outpatient 3 DOA 1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day, Year 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred cation: 1 Natural 5 Pending Director: d in by the f 1 Yes 2 X No fd 1-7-11 fd 5:08pm subject was exposed to cold 2 X Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 2300 Washington Blv1.
Balto. City, Md 21230 28e. Place of Injury - At home, farm, street, factory, office building, etc Certifi 3 Suicide Could not be within 24 hours af

To the Funeral D

completely filled i determined (Specify) found outside under a bridge 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Sa 2 Wedical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) W O.C.M.E. January 8, 2011 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

ORIGINAL

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND #20A State of Maryland 7 Department of Health and Mental Hygiene 11-00259 Sandra Gail Delacruz 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Month Day January 9, 2011 Medical Examiner 0954 hrs Sandra Gail Delacruz 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 3616 Hillsdale Road Baltimore 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign **Funeral** Months Davs Hours Mary land Director Aug 16, 1960 50 215-78-9968 1 M 2 X F Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No Baltimore 28a-f show MD Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

sant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21215 3616 Hillsdale Rd Funeral 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No. Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 X Married 1 Yes Specify: Hispanic 3 Widowed If Yes. Give Year 1 X Yes 2 No specify: 4 Divorced <u>۾</u> 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) timore, MD 21215-0036 food industry 0 cook 17. Father's Name (First, Middle, Last) 18 Mother's Name (First\_Middle\_Maiden Surname) æ Ollie May Polliend Basil Eades 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2314 Chand Dr; Joppa, Maryland 21085 Victor M. Maisonet Jr. - son 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State crematory or other place) Department of Important: I 2/06/2011 WOODBINE .MD. FINAL JOURNEY CREM Donation 5 K Other Specify: in State 21. Signature of Funeral Struce Licensee Wage pirector MARYIAND ER MATION SERVICES PBOR 1413 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart proxima e Interval **Physician** List only one cause on each line Between Onset and /Medical Death a Oxycodone Intoxication Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed and Physician/Medical UNPENDED **AMENDED** attending physician or use as the burial Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 3b. Was decedent pregnant in the Live birth 2 Fetal death 3 Ectopic pregnancy Day Year past 12 months? Pregnant at time of death 5 Other (Specify) icate has been signed by the att page 2 should be detached for 1 Yes 2 No 9 ✔ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 No 3 Probably 4 V Unknown Hypertensive atherosclerotic cardiovascular disease Completed 24a Was an 24b. Were autopsy findings available prior to completion of cause of autopsy certificate has . death? performed? Yes 2 No 1 🗸 Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Hospital or Attending Physician: Be examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other; Nursing Home 5 Residence 6 ✔ Other: Scene this 1 🗸 Yes No After th 28a. Date of Injury FOUND: Pay, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Unknown FOUND: within 24 hours after death.

To the Funeral Director: A completely filled in by the fu Natural filled in by the f 1 Yes 2 ✔ No 5 Pending 2 Jan 9, 2011 0930 hrs Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 6 🗸 Could not be Suicide or Town, State) 3616 Hillsdale Road, Baltimore, MD determined (Specify) Basement Apartment Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) January 10, 2011 OCME. OLV 30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 32. Registrar's Sanatui

DHMH 17 Rev 1/2001 **OCME 2006** 

State

Registrar

2011

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Physician/ 059 BM LUGENE UAUSON mome Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 802 MILLS Circle A PONSUILLS BALTMOR 8. Date of Birth (Month, Day, Yea Social Security Number If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) 9. Birthplace (State, or Foreign **Funeral** 1 M 2 🗆 Months Hours Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important If item 27 is marked other than "natural". or incorporation of the traumatic event "..." 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Directo TULSUI 1 Yes 2 THG BALTINEK MAYYLAW 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA -INCle Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, 1 Never Married Married 1 Yes ģ 2 No 1 Yes 2-No Specify. Specify: Slack 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (9-12) College (1-4 or 5+) andi Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ ICKErson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1CHE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State WOOD LOOK 4 Donation 5 Other (Specify) Life m KM AL 21. Signature of Pyneral Service Lice y ee 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Cance yers elon Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical þ Completed

Division of Vital Records, P.O. Box 68760 Hospital or Attending Physician: funeral director, within 24 hours after deat To the Funeral Director: completed filled in by the

Be P. Certificate:

Medical

only one) 29b. Signatu

31. Date filed (Month, Day, Year)

and file of certifier

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy  1	ic pregnancy (specify)		23d. Date of delivery Month Day Year
Part II. Other significant conditions	contributing to death but not resulting in the underlyin	g cause given in Part I.		o use contribute to the cause of death?  2  No 3 Probably 4 Unknown
			24a. Was an autopsy performed?	
25. Was case referred to medical		26. Place of Death (Check of	only one)	
examiner? 1  Yes 2 No	Hospital: 1	DOA Other: 4 \( \sum \) Nursing Hom	e 5 Residence	6 Other (Specify)
27. Manner of Death  Natural 5 Pending  Accident Investigation		28c. Injury at work?	d. Describe how inju	ury occurred
3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determined	1 200 Place of Injury - At home form street fact	ory, office 28	Bf. Location (Street a City or Town, Star	and Number or Rural Route Number, te)
(Check 2 Medical Exar	ysician: To the best of my knowledge, death occured niner: On the basis of examination and/or investigation, irse Practioner: To the best of my knowledge, death oc	in my opinion, death occurred at the	ne time, date and place	ce, and due to the cause(s) and manner stated

29d. Date signed (Month, Day, Year)

Janson My

Registrar DHMH 17 Rev 7/2009

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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			Registrar  1. Decedent's Name (First, Middle	l ast)	2. Date of Death	g. No.	03045	1					
П	Physicia		CLAY	DELL	NDS				Month FEBRUARY	Day Year <b>4. 201</b>		√I	
a	Medio Examin		4a. Facility Name (if not institution,	,					tion of Death	PEDRUARI	4c. County of De	eath	
	/ 		1929 Gillis Fa		-			dbine	0.4 Llus		Carro		
	Funeral Director		212–50–2069	6. Sex 1 <b>X</b> M 2 □ F	e (In yrs. la:		If Under 1 Months	Days Hou	nder 24 Hrs. urs Min.	8. Date of Birth (Month, Day, Yo NOV • 16	, 1947 1	Birthplace (State or Foreign Country) Lary Land	n
	nd now at	_	Usual Residence of Decedent  10a, State 10b, County		10c City	Town or Loc	cation					10d. Inside City Limits	_
	farylar 8a-f sl tified	ecto	Maryland Ca	rroll		oodbir						1 ☐ Yes 2√√ N	
	th with the Maryland ms 23a or 28a-f show must be notified at	Funeral Director	10e. Street and Number 1929 Gillis Fa	11s Road			10f. Zip C	<sup>21797</sup>	7	10	g. Citizen of What (		
980	permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu once.	by	11. Marital Status  1 Never Married 2 Marr 3 Widowed 4 Divorced	If Von Cive	No <b>VIET</b>	INAM-	Yes, specify	nt of Hispanio y Cuban, Me: ☑ No Spe	xican, Puerto	cify Yes or No- Rican, etc.)	14. Race - An Black, Wh Specify:	nerican Indian, nite, etc. White	
5-0	2 hours "natur dical	plete		nt's Education est grade completed)		16a. Deced	ent's Usual (	Occupation	most of worki	10	3b. Kind of Busines	is Industry	
Maryland 21215-0036	thin 72 ene. than he Me	Completed	Elementary/Seconday (0-12)	College (1-4 or 5	5+)	life. DO	NOT use re	etired)	THOSE OF WORK	ig .	Self-emp	oloved	
1d 2	iled wi I Hygie other ent, t	Be	10th 17. Father's Name (First, Middle, L	ast)		Aut	.o neci		Mother's Name	e (First, Middle, Ma		/LOY Ca	
ylar	ld be f Menta arked atic ev	P	Frank C. Fali	.se				]	June		Bell		
Mar	shou hand 7 is m traum		19a. Informant's Name/Relationsh			l .	•				ity or Town, State,	·	
	f Healt f Healt item 2 other	1	Jeanie Edmonds 20a. Method of Disposition	Wife		ace of Dispos	sition (Name	of	ls Roa		ine,MD 2		_
Baltimore,	Page trnent o tant: If jury or		1) X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S			metery, crem rgan (			Feb.	8, 2011	Woodbine		
Bal	permit Depart Impor any in	À	21. Signature of Funeral Service L	aully	/	22 Bu	Name and Irrier 12 W	Address of F Oueer	Finer	al Home Road Wi	& Cremat	ory, PA 4D 21784	7
			23a. Part 1. Enter the disease, or shock, or heart failure. List o	nly one cause on each line	Э.		r the mode o	of dying, sucl	h as cardiac o	r respiratory arrest	,	Approximate Interval Between	
	Ph_sician/ Medical	7 7	Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as								Onset and Death	_
Sare	Examiner		Sequentially list conditions,	h ———	a conseque	Silide Oilj.							
-	ed sit	Examiner	cause. Enter Underlying Cause (Disease or linjury	Due to (or eas	е попенции	nnes cry							
	ate be executed physician and the burial-transit	Exa	that initiated events resulting in death) Last	c. — Due to (or as a	a conseque	ence of):							
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68760	rtificat ling ph e as th	/Mec	IF FEMALE:	222 16 112 214 227	-							1	
Вох	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transitions.	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome 1	2 Fetal	death 3	Ectopic pre Other (spec				23d. Date of d Month	delivery Day Year	V
P.O.	es that the designed by the signed by the signed by the signed by the signed is the signed in the signed is the signed signed in the signed signed in the signed si		Part II. Other significant conditio	-		lting in the ur	nderlying cau	use <i>g</i> iven in f	Part I.			to the cause of death?	
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of Vital Records,	: The law r cate has b ; page 2 sl	Completed by								24a. Was an autopsy performe 1  Yes 2	prior to death?	autopsy findings available o completion of cause of ? les 2 \( \text{\subset} \) No	'
/ital	Physician: The this certificate ral director, pag	To Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital:	ant 2 🗆 E	R/Outpatien		1	Death (Check		ce 6 🗆 Other (Spe		
on of	nding Phy ath. r: After this e funeral c	Certificate: T	27. Manner of Death  1 Natural 5 Pending 2 Accident Investig	28a. Date of injur (Month, Day	ry 2	28b. Time of injury		Injury at work?	2	28d. Describe how		спу)	
Division	after deatl Director.	Certif	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determi		iry - At hom c. (Specify)	ne, farm, stre	et, factory, o	office		28f. Location (Stree City or Town, S		Rural Route Number,	٦
Ω	To the Hospital or Atter within 24 hours after de To the Funeral Directo completed filled in by th	Medical	(Check 2 Li Medical E	Physician: To the best of examiner: On the basis of ex Nurse Practioner: To the	xamination :	and/or investi	gation, in my	opinion, dea	th occurred at	the time, date and r	place, and due to the	e cause(s) and manner state	ted.
_	To th withiu To th comp		29b. Signature and title of certifier	Slack.	(		29c. L	icense numb	per	290	I. Date signed (Mon	th, Day, Year)	
			30. Name and address of person v	vho completed cause of de	eath (Item 2	23a) (Type, Pı	rint)						
۲ ۱			KAREN ANN BLACK				IRVIN	G STRE	ET NW,	WASHING'	CON, DC 20	422/088	
	Stat Registra	_	31. Date filed (Month, Day, Year) • FEB 0 7 201	82 Registra	ars Signatu	re Marks	1						

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No.( 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2011 Moses Lee East, Sr. February 7:10AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 11419 Flowerton Place Germantown <u>Montgomery</u> Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** Date of Birth (Month, Day, Birthplace (State or Foreign Country) Months Days Hours Min Director Yrs 241-17-9996 1959 North Carolina Usual Residence of Decedent 23a or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits d Mental Hygiene. marked other than "natural", or items 23a or 28a-f st matic event, the Medical Examiner must be notified i 1 ☐ Yes 2 X No Maryland Montgomery Germantown 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 11419 Flowerton Place 20876 United States 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces Black, White, etc. ò 1 Never Married 2X Married Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. 3 Widowed 4 Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done (life. DO NOT use retired) during most of working Elementary/Seconday (0-12) College (1-4 or 5+) Truck Driver Trucking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Ulice Matthew East Lucy Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11419 Flowerton Place, Germantown, Maryland 20876 Beverly Nelson / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Souls Cemetery Germantown, Maryland 21. Signature of Fundam Service Licenses 22. Name and Address of Facility Robert A. Rockville, Inc. 300 Wes Rockville, Maryland 208 A. Pumphrey Funeral Home/ lest Montgomery Avenue 10850-2805 Part 1. Enter the disease, or conshock, or heart failure. List only plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Extensive Stage Small Cell Cancer to Brain Months Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate Physician/Medical Examiner Due to for as a consequence of cause. Enter Underlying Cause (Disease or linjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Pregnant at time of death Month Day Year 2 No n signed by the a lid be detached f g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 含 Completed 1X Yes 2 □ No 3 □ Probably 4 □ Unknown page 2 should peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of Jas autopsy within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page performed? Yes 2 X No death? Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 1 Yes 2 X No မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending Accident Suicide Investigation 1 Tes 2 🗌 No 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) al Banner MD060335 MD 2011 February 3, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar DHMH 17 Rev 7/2009 Α.

31. Date filed (Month, Day, Year)

FEB 0 7 2011

Bannen, M.D.

ack

32. Registrar's Signature

18111 Prince Philip Drive, Olney, Maryland 20832-1507

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. AMEND #17&18 PER ANA BD G912 2/07/2011 JH State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 27 -2011 1:30 Wade Madison Etchison January АМ 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 2100 Bollinger Mill Road Finksburg Carroll If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, May 23, 9. Birthplace (State or Foreign Country) MaryLand 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) 1⊠ M 2□ F Months 216-07-9190 93 Usual Residence of Decedent 10h County 10a State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 21K No Carroll Finksburg MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21045 2106 Bollinger Mill Rd 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 1 X Never Married 2 ☐ Married Specify: White If Yes, Give Year or Dates: 1 ☐ Yes 2X No Specify 1947 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) unk unk electrical engineer Westinghouse Father's Name (First, Middle, Last)
JAMES BOWIE ETCHISON
Kenneth Etchison 18. PEARL Name (First Middle Maiden Survame 961 Redfield Rd Apt D; Bel Air, MD 21014 rother 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 961 Redfield Rd Apt D; Bel Air, MD 21014 Kenneth Etchison - brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility State Anatomy Board reof Ringra Service Sicense ad Director 655 W. Baltimore St; Baltimore, MD 21201 in 23a. Pan 1. Enter the dise se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest show or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final schemic week disease or condition resulting in death) Due to (or as a consequence of): Taberes Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in itilated events resulting in death) Last Due to for as a consequence of Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day -Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ Ho 3 ☐ Probably 4 ☐ Unknown pertonton 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐Yes 24No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Physician /Medical Examiner

permit. Pages 1
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Important: If itel
any Injury or ott

other 1

**Physician** 

/Medical

Examiner

Director

Funeral

2

Completed

Be

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**Funeral** 

Director

filed within 72 hours after death with the Maryland

Maryland 21215-0036

Baltimore,

1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene.

em 27 is marked other than "natural", or items 23a or 28a-f show wither traumatic event, the Medical Experience must be notified at

Hospital or Attending Physician: The law requires that the death certificate be executed

and burial-1 the attending physician ned for use as the burial the signed by the has certificate this After 1 after death

24 hours a

within 2

Division of Vital Records, P.O. Box 68760.

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22	Physician/Medical
	6
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	ation:

Examiner

Certific filled in by Medical

1 Yes 2 No

5 Pending investigation

6 Could not be

Year

determined

27. Manner of Death

1 Natural

2 Accident

4 ☐ Homicide

(Check only one)

29b. Signature and title of certifier

30. Name and address of per

31. Date filed (Month, Day,

3 Suicide

29a, Certifier

Sta	te
Registr	ar

DHMH 17 Rev 1/2001

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

28c. Injury at Work?

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

1 ☐ Yes 2 ☐ No

28a. Date of Injury (Month, Day, Year)

who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ ECHAN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death HOSPITM CARROLI LINTER WESTUINSTEA If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Days Min. 1 M 2 X F 59 0872271951 Marviiand Director 215-58-3956 Usual Residence of Deceden 28a-f shov 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits should be filed within 72 hours after death with the Maryland I and Mental Hyglene. I sho it is marked other than "natural", or items £3a or £8a-f sho it is marked other than "natural", or items £9a or £8a-f sho raumatic event, the Medical Examiner must be notified at raumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No Md Carroll Sykesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 7111 Gaither Rd. 21784 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married ğ 1 Yes If Yes, Give 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 KNo Specify: 3 Widowed 4 Divorced White Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Nursing Yrs. Nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ഉ permit. Page 1 and 2 should be f Department of Health and Menta Important; If item 27 is marked any injury or other traumatic ev Frank Kershman Regis Traylor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7111 Gaither Rd. Sykesville, Md. 21784. Edward J. Feehan (Husband) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State All County Cremation 02/06/2011 Sykesville,Md. 21784 4 Donation 5 Other (Specify) 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licenses P.O. Box 195 Sykesville, Md. 21784. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner equentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Intravescular Coapulation requires that the death certificate be executed and -tran Due to (or as a consequence of resulting in death) Last attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 movins?

1 Yes 2 No
9 Unknown Pregnant at time of death the a g Unknown P.O. has been signed by e 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tyes 2 No 3 Probably 4 Unknown Records, Were autopsy findings available prior to completion of cause of 24a. Was an autonsy page death? certificate 1 ☐ Yes 2 ☐ No **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) examinor? Other: 2 🗆 No မ Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural injury work?
1 ☐ Yes 2 🗆 No M 2 Accident Investigation ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signatu 29d. Date signed (Month, Day, Year) D0027619 2011 IDV 1838 Greene The Road - #420 southmore, 1

DHMH 17 Rev 7/2009

State

Registrar

21208

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death ept's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Mon Medical Name (if not institution, give street and number) 4b. 2110. Town, or Location of Death Examiner HMORE If Under 1 Year Lae (In yrs. last birthday) If Unde 8. Date of Birth 9. Birthplace (State Country) **Funeral** Foreign Mont Director 212-28-16 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ms 23a or 28a-f sho must be notified at 10d. Inside City Limits Director 1 Yes 2 No town 10e. Street and Numbe 10g. Citizen of What Country? Funeral 12020 items 23a 3 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Examiner ō Completed by 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2 No Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. "natural" 3 ₩Widowed 4 □ Divorced Year or Dates f Health and Mental Hygiene. item 27 is marked other than "natur other traumatic event, the Medical 16a. Decedent's Usual Occupation
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Alife DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) nday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden St မ ากรоท 19a. Informant's Name/Relationship (Type, Print) homas rance lorning oodstre Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date permit. Page 1 a Department of H Important: If ite any injury or ot **☑** Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or off 4 ☐ Donation 5 ☐ Other (Specify) 2-7-2011 21. Signat e of Funeral Se 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. rval Between Immediate Cause (Final Onset and Death Physician PNEUMONIA disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner PHAGIA Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): the burial-transit EREBROUBSCULAR attending physician and for use as the burial-trar that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 mbnths? 1 ☐ Yes 2 ☑ No Month Day Year Pregnant at time of death 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by AIZHEIMER'S DEMENTIA 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 s performed? Yes 2 No 2 🗌 No 1 Tyes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 3 No Other: ျှ 1  $\square$  Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural work? 5 Pending within 24 hours after death.

To the Funeral Director: At completed filled in by the fu 1 Tyes 2 No ☐ Accident Investigation 3 ☐ Suicide 4 ☐ Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 32011 088852 21209 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature

TAMMA

C.

32. negistrar s Signature

CAN

2835 Smith Bomuz #203 (Sourius)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. -1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2011 Francis John February Ford 8:21 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 12 Cold Spring Court Potomac Montgomery Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral Birthplace (State or Foreign Country) Days 1 ፟፟፟ M 2 □ F Months Hours Min (Month, Day 161-28-1148 Director 76 December 8, Pennsylvania Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he notified at 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 🗆 Yes 2 🏝 No Maryland Montgomery Potomac 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12 Cold Spring Court 20854 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☒ No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify: White 3 Nidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) **5+** Attorney Legal Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ John Ford Anna Carney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Old Club Court Rockville, Maryland 20852 Susan F. Campbell / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1  $\boxtimes$  Burial 2  $\square$  Cremation 3  $\square$  Removal from State February St. Gabriel's Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2011 Potomac, Maryland 21. Signature of Furieral Sept ce Lice Robert A. Pumphrey Funeral Home Rockville, Inc. M01607 300 West Montgomery Avenue Rockville, Maryland 20850 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Coronary Artery Disease disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Duc to for as a sunsequence of, Examil the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Pregnant at time of death Month Dav Year signed by the a d be detached f Yes 2 No Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 23e. Did tobacco use contribute to the cause of death? Completed 1 Yes 21 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy performed' certificate 2 🗆 No Yes 2 No completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 X No Other: ၉ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA After this 4 ☐ Nursing Home 5 K Residence 6 ☐ Other (Specify) Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury work? 24 hours after death. Funeral Director: A Accident Investigation 1 Yes 2 No 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide determined Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of c 29c. License number 29d. Date signed (Month, Day, Year) D35370 2/2/2011 of death (Item 23a) (Type, Print) 30. Name and address of person who completed cau Bachowski, 11125 Rockville Pike #104 M.D. Rockville, Maryland 20850 filed (Month Day, 31. Da Year)

DHMH 17 Rev 7/2009

Registrar

**ORIGINAL** 

32. Registrar's

Maryland 21215-0036 Baltimore, 68760 Box P.O. Records, of Vital

Division

D61731 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TOWSON, MARYLAND REGINA GAN-CARDEN, M.D. 7601 OSLER DRIVE 31. Date filed (Month, Day, Year) State FEB 0 Registrar ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month BARBARA ANN GORDON 7:35 P.M FEBRUARY 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** STELLA MARIS HOSPICE TIMONIUM BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Social Security Number . Age (In vrs. last birthday **Funeral** 1 🗆 M 2 🔀 F Months Hours **Director** <del>213-52-9</del>295 65 9/4/1945 MARYLAND Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 Yes 2 X No BALTIMORE MD PARKVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8614 RICHMOND AVENUE 21234 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc. Completed by 1 X Never Married 2 Married 1 ☐ Yes 2 ☐**X**No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: WHITE 3 Widowed 4 Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) BALTIMORE CITY Elementary/Seconday (0-12) College (1-4 or 5+) SCHOOL SYSTEM 4 YEARS TEACHER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 VERNON LEROY GORDON ANNA R. ONDERDONK 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) MORRIS GARTEN/ATTORNEY 36 S. CHARLES ST. SUITE 2300 BALTIMORE , MD 21201 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a, Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State MORELAND MEM. PARK 2/11/2011 HILLENDALE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 21286 8521 LOCH RAVEN BLVD. TOWSON, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Litter U. denying Cause (Disease or iinjury Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): been signed by the attending physician should be detached for use as the burial Be Completed by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year 5 Other (specify) 1 L Yes 2 Dunknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an completed filled in by the funeral director, page 2 autopsy perform 1 Yes 2 No Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence မ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this . Manner of Death 1 Natural Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation 24 hours after deat 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2 To the I only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. erson who completed cause of death (Item 23a) (Type, Print) 30. Name and 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

#9,11,12,15,16A,17,18&19A&B PER ANA BD G912 2/07/2011 JH

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 10 131 AM (rardner 24 2011 JAN /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimere Good Samaritan Hospital City Baltimore 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday **Funeral** Days Hours Months 212-52-8472 1 XM 2 F 52 MARYLAND Director 22 -1958 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Farmaconce. 10b. County unk 10c. City, Town or Location 10d. Inside City Limits 10a, State ınk¥XYes 2□No Completed by Funeral Director MD BALTIMORE 10e. Street and Number unk 10f. Zip Code unk 10g. Citizen of What Country? USA 2319 MONTQBELLO TERRANCE 21214 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Never Married 2 Married black 1 ☐ Yes 2 ZNo Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation

(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 12 SECURITY OFFICER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ( BEATRICE DIGGS JAMES FONNOU GARDNER, SR ၉ 192219 MONTOBELLO TERRANCE NUBAL TIMORE SMD 2024214 19a. BEATRICE GARDNER MOTHER 5601 Loch Raven Blvd; Baltimore, MD 21239 Good Samaritan Hospital 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ② Other (Specify) in State Signature of Euneral Service Licensee 22. Name and Address of Facility State Anatomy Board Director 655 W. Baltimore St; Baltimore, MD 21201 23a. Pa. 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Intarction Myocardia /Medical Due to (or as a consequence of): Examiner pertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner g physician and is the burial-transit Hospital or Attending Physiclan: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð demia 1 Yes 2 No 3 Probably 4 Vunknown Completed othyroidism 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Encephalopath this certificate Hashimoto 1 ☐Yes 2 ☐ No 1 ☐Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ★ER/Outpatient 3 ☐ DOA Certification: To after death, I Director: After this d in by the funeral d 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation М 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated within 2 To the I 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 25 D 34851 MA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5601 Loch Raven Boulevard, Baltimore MD 21239 MD 32. Registrar's \$ gnatur State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician/ ohn :45 AM an 2011 Medical 4a. Facility, Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** RRRO olden LIVING untek lest muste If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🔀 M 2 🗆 F Days Min. Oct 21, Year) 918 Months Hours Massachusetts Director 013-03-0464 92 Usual Residence of Decedent a or 28a-f show be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 Yes 2X No Carroll Westminster MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code iral", or items 23a oi Examiner must be Funeral USA 21157 412 Baldwin Park Dr; Apt T-1 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian Armed Forces?

1X Yes 2 \( \sum\_{No} \) 1944-Black, White, etc. 1 Never Married 2 Married δ white If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 12 should be filed within 72 noussemath and Mental Hygiene.
A 27 is marked other than "natural" "natural", 1946 Completed 3 Widowed 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Simonds Saw & Steel unk foreman unk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Apolonia Konieczney Frank Glister 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health a Important: If item 27 is any injury or other tra Janis Hagert – daughter 3405 Blueberry Lane; Reisterstown, MD 21136 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burlal 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) use of Experal Service License Software S 22. Name and Address of Facility State Anatomy Board 21. Signat Director 655 W. Baltimore St; Baltimore, MD 21201 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ CAY resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of): attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Year Dav Pregnant at time of death signed by the a Id be detached f Yes 2 No g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown cate has been siç ; page 2 should b 24b. Were autopsy findings available prior to completion of cause of death? performed? Yes 2 No 2 1 No 1 Yes 25. Was case referred to medical examiner? the funeral director, Be 26. Place of Death (Check only one) Hospital: 2 **N**o မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28c. Injury at work?
1 Yes 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: Natural 5 Pending 24 hours after death. Funeral Director: A Accident
Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide completed filled in by determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 within 2 only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2011

Registrar

DHMH 17 Rev 7/2009

State

Baltimore, Maryland 21215-0036

68760

Box (

P.O.

Records,

Division of Vital

Stoner

No 21157

**ORIGINAL** 

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

291

CHACKO

DINU

31. Date filed (Month, Day, Year)

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Haroach , Lune 1	Baltimore, Maryland 21215-0036
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Division of Vital Records, P.O. Box 68760,

		State of Maryland / Dep	artment of Health and Men	
		10	rtificate of Death	Reg. No. 2 1 1 1 1 5 9
Physici		1. Decedent's Name <i>(First, Middle, Last)</i> Anne Marie Hubbach		anuary 31, 2011 2:50 PM
/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
		College Manor	Lutherville	Baltimore
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 219-05-0707 1 M 2X F 92 Yrs.	Months Days Hours Min. Se	pate of Birth 9. Birthplace (State or Foreign Country) pt 21, 1918 Colorado
and w		Usual Residence of Decedent  10a. State		10d. Inside City Limits
Maryla I-f sho	tor	MD Baltimore Luthery		1 ☐ Yes 2 ☐ No
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Modical Examiner must be notified at once.	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
eath w	Funeral	300 W. Seminary Ave.  11 Marital Status 12. Was Decedent Ever in U.S. 13.	21093	USA Yes or No- 14. Race - American Indian.
after d		1 ☐ Never Married 2 ☐ Married   1 ☐ Yes 2 🛣 No	Was Decedent of Hispanic Origin? (Specify If Yes, specify Cuban, Mexican, Puerto Ricar	white
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d be fill ental H ed oth	Be c	17. Father's Name (First, Middle, Last)  Lawrence Mossman	18. Mother's Name (First Magdalene	st, Middle, Maiden Surname) Holman
should and Me s mark	ပ		ng Address (Street and Number or Rural Roo	ute Number, City or Town, State, Zip Code)
and 2 lealth m 27 is	3		Northwood Dr; Timon	
ages 1 int of H t: If ite / or ot		The building of the moval front State	osition (Name of Date matory or other place)	20c. Location - City or Town, State
mit. Parame sortani r Injury	3	4\\ Donation 5 \  Other (Specify)  21. Signature of inneral Service Licensee Service	: 2. Name and Address of Facility State	Anatomy Board
an)		Senn 1/leur		Baltimore, MD 21201
Physician /Medical Examiner	iner	23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, of heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a	f fem in Fracture	piratory arrest,  Approximate Interval Between Onset and Death
Jeath certificate be executed attending physician and for use as the burial-transit	/Medical Examine	that initiated events resulting in death) Last  C. Due to (or as a consequence of):  d	**	23d. Date of delivery
the death by the atter ached for u	Physician/Medi	in the past 12 months?	☐ Ectopic pregnancy ☐ Other (specify)	Month Day Year
The law requires that the death certifica ate has been signed by the attending phoage 2 should be detached for use as the	þ	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?  1 □ Yes 2 □ No 3 □ Probably 4 ★ Unknown
ate has be	Completed			24a. Was an autopsy findings available prior to completion of cause of death?  □ Yes 2 ▼No 1 □ Yes 2 ▼No
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ig Pny ter this neral d	n: To	27. Manner of Death 28a. Date of Injury 28b. Time of	1 3 DOA 4 Nursing Home	5 Residence 6 Other (Specify)
tendir leath. tor: Af the fur	catio	Accident investigation December 29,2010 155 P	M 1 □Yes 2 No	tall
after of Direct of In Direct of	Certification:	3 ☐ Suicide 4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide  4 ☐ Homicide	11. 15.1.	ocation (Street and Number or Rural Route Number, City or Town, State) 460 G eo + 9 G Court
to one hopping or Attending Physician: The law within 24 bopping or Attending Physician: To the Funeral Director. After this certificate has completely filled in by the funeral director, page 2 s	edical C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, dea 2 Medical Examiner: On the basis of examination and/or in and manner stated.	occurred at the time, date and place, and o	due to the cause(s) and manner as stated. the time, date and place, and due to the cause(s)
Vithii Comp	Me	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
		30. 11 me and ad ress of person who completed cause of death (Item 21a) (Typ.	Print)	11 tebruary 2,2011
		Thilip Miltello, MD to Trimb  31. Date filed (Morth, Day, Year)  32 Registrar's Signature	le Hill CT, Luthono	:11e,Md21093
Stat Registra		FEB 0 7 2011 Same B. A.	arles	February 2, 2011 :11e, Md21093

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Milary 10 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death allas If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours oth, Dayn Director Usual Residence of Decedent 28a-f show 10b. County 10a. State event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🗆 No 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? Funeral 23a permit. Page 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hygene. Important: If item 27 is marked other than "natural", or items; any injury or other traumatic event, the Medical Examiner mus any injury or other traumatic event, the Medical Examiner mus 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cyban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?/
1 Yes 2 No Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 M No Specify: If Yes, Give Year or Dates Specify. Completed 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) ementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ lwman 19a. Informant's Name/Relationship (Type, Print 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) eighton 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location (- city or Town, State cemetery, crematory or other p 4 ☐ Donation 5 ☐ Other (Specify) any inj once, 21. Signature of Funeral Service License Harn's Fineral 23a. Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death
2-3day Immediate Cause (Fnal Physician/ VICAL Illness otherwise disease or condition Medical resulting in death) Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (brids a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi and Due to (or as a consequence of): signed by the attending physician d be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by End Stage renal disease 1 🗆 Yes 2 🗆 No 3 🗆 Probably 4 🗗 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hepanins , page 2 After this certificate has autopsy performed Yes completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: မ 2 🗌 No 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Accident 1 Yes 2 🗌 No Investigation 124 hours after death e Funeral Director. 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Efertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 To the F only one) 29b. Signature and title of cert 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 FASTERN BATMORAMD M.D 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 0 7 2011 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last)
Sherry Elizabeth Hunter 2. Date of Death 3. Time of Death Month Physician/ 15:34 PM anuary 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore of Baltimore Tilmore a if Under 1 Year If Under Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 F Min. Country) IN 36 Months Days Hours 049/29/1974 216-86-1871 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Important: I flem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10c. City, Town or Location
Parkville 10b. County 10d. Inside City Limits 10a. State Director Baltimore MD 1 🗆 Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 21234 9210 Smith Ave USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 🗓 No 1 Never Married 2 Married ğ 21215-0036 1 Yes 2 No Specify: White Specify: If Yes. Give 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) 2 yrs Elementary/Seconday (0-12) Homemaker Homemaker Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Unavailable Unavailable 19a. Informant's Name/Relationship (Type, Print) Eric Hunter Spouse 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9210 Smith Ave Parkville MD 21234 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Atlantic Crem 1 Burial 2 X Cremation 3 Removal from State 2/1/2011 Glen Burnie MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Simplicity Cremation and Fun Thomas Allen PA 7090 Ridge Rd Hanover MD 21. Signature of Funeral Service License 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and D ath Immediate Cause (Final Sefsis Physician disease or condition resulting in death) Medical Due to (or at a consequence of) **Examiner** Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of Examir ending physician and use as the burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 attending IF FFMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Year Day Pregnant at time of death 2 🗌 No sate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law autopsy performed?

1 Yes 2 No certificate 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work' 1 🗌 Yes 2 🗌 No Investigation 6 Could not be ☐ Accident 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🗗 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 20 ZON anuary

State Registrar 31. Date filed (Month, Day,

Sherry

Known

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month HANE PANUMORI Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CENTER RANDALISTONA BALT. NONE KONTHWEST If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 219-58-6573 **Funeral** Days Months Min. 0974674949 Country) 61 MD **Director** Usual Residence of Decedent or 28a-f shov 10b. County 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a, State 10c. City, Town or Location other traumatic event, the Medical Examiner must be notified at Director Owings Mills MD Baltimore 1 Yes 2 X No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 21117 13 Oakmere Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 White 1 ☐ Yes 2XXNo Specify: 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Automotive Parts Advisor Be ather's Name *(First, Middle,* Harold A. 18. Mother's Name (First, Middle, Maiden Surname) Hasti 19a. Informant's Name/Relationship (Type, Print)
Cindy Hahn / Spouse 19b Mailing Address (Street and Number or Rural Route Number City or Town, State Zip Code) 117 13 Oakmere Road, Owings Milis, MD 21117 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1
Department of Important: If it any injury or o 1 Burial 2 X Cremation 3 Removal from State Final journey Crem. 02/05/2011 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Maryland Cremation Services
PO Box 1413, Baltimore, MD21203 Signature of Funeral Service Licensee Porpta Marshall - Mous 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ SEPSIS Medical Due to (or as a consequence of): Examiner NEUMONIA Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of) Cause (Disease or linjury the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Day 5 Other (specify) Month Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by HEART FAI lune, RESPIRATING FAILURE Division of Vital Records, 2 No 3 ☐ Probably 4 ☐ Unknown 1 🔲 Yes Concovery Antery DISTASE; 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed huyouandial intranction 2 AN 1 Tes 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 700 1 Inpatient 2 🗆 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 Natural 5 🗌 Pending 1 🗆 Yes 2 No within 24 hours after death.

To the Funeral Director: A ☐ Accident ☐ Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Cortifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated Cortifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 7/2009

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1 Decedent's Name (First Middle | ast) 2. Date of Death Physician/ Month Medical Examiner 4a. Facility Name (if not institution, 4b. City, Town, or Location of Death 4c. County of Death If Under 24 Hrs. 8 Date of Birth Birthplace (State or Foreign Country) **Funeral** Min (Month, Day, 1**X** M 2 □ F 49 Director 220-76-792 /5/1960 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland the Medical Examiner must be notified at Director MD Baltimore City 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō Funeral 23a 1507 Mulliken Court 21213 USA items 2 death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. "natural", or δ 1 Never Married 2 Married within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ XNo Specify: Specify: Black If Yes Give 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry and Mental Hygiene. Home Elementary/Seconday (0-12) College (1-4 or 5+) Improvement Laborer other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked c any injury or other traumatic eve ဥ Catherine James Powers Mary 19a. Informant's Name/Relationship (Type, Print) 50 W 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3229 Hoffman Street Balto MD 21213 Antonio Jackson 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State 2/11/11 4 ☐ Donation 5 ☐ Other (Specify) Mount Balto MD 21. Signature of Funeral Service Licensee 22. Name and Address of FacilitPhillip A Weatherford PS PA 2431 Ε. Oliver St Balto MD 21213 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to of as a consequence of Examin attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical or Attending Physician: The law requires that the death certificate be Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death signed by the a d be detached for Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has the lirector, page 2 s autopsy 1 Yes 2 No 1 Yes 2 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) director, Be examiner? Hospital Other: 1 🗆 Yes 2 No 1 Donpatient 2 ER/Outpatient 3 DOA ျှ 4 Nursing Home 5 Residence 6 Other (Specify) this funeral 27. Manner of Death 28a. Date of injury 28b. Time of I Director: After to in by the funeral Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural Accident 5 Pending M 1 Tes 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide after determined To the Hospital within 24 hours a To the Funeral D Medical 29a. Certifier Ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. сотріете Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 31. Date filed (Month, Day, Year State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician/ ORMA ENS Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Howard Columbia HOWARD If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign . Age (In yrs. last birthday, **Funeral** 1 □ M 2 🖾 F 77 Months Days Hours Nebraska 506-38-1539 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural" any injury or other traumatic event". 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1 Yes 2 X No Laurel MD Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 20723 9622 Washington Ave. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🛣 No Black, White, etc. þ 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 ₺ No Specify: Specify: white Completed 3 X Widowed 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ Jessie Heim James R. DeWeese 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8026 Hadfield Ct., Pasadena, MD 21122 Daughter Vicky <u>Ingram/</u> 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place) 1 XXBurial 2 ☐ Cremation 3 ☐ Removal from State Milton, DE Henlopen Mem.Park 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Donaldson Funeral Home, P.A. . Signature of Funeral Service Licensee Ken 313 Talbott Ave., Laurel, MD 20707 M01053 23a. Plan 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ PROBABLE disease or condition resulting in death) COPUNAM Medical Due to (or as a consequence of): Examiner AMON APPY Sequentially list conditions. Examiner Due to (or as a consequence of) if any, leading to infinediate cause. Enter Underlying Cause (Disease or linjury 25NE 12AV1250 that initiated events Due to (or as a consequence of) resulting in death) Last Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? FIBRILL ATION; Ity po the yeard is'm Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 Yes 2 No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: ည 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After Natural Accident injury work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or inventional control of the property of th Medical 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie

State Registrar

10

32. Registra 's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Stephen R. Knazik,

H0069342

D.O.,5755 Cedar Lane, Suite 134, Columbia, MD 21044

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ :50.4 anuar Theresa McKay Kemp Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner Baltimore Washington Medical Center Anne Arundel Glen Burnie If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days April 25,1943 1 □ M 2 🗓 F Hours Washington, DC 579-56-3963 Director Usual Residence of Decedent or 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 🛣 No Maryland Anne Arundel Jessup 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral United States 20794 7513 Gleneagle Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. þ 1 Never Married 2 X Married ☐ Yes 2 🛛 No 1 ☐ Yes 2 X No Specify: Specify: White Maryland 21215-003 If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Accounting Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary Ryan Joseph Bernard McKay 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7513 Gleneagle Drive, Jessup, Maryland 20794 Robert G. Kemp, Jr./Husband Baltimore, 20a Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State west Arundel Crematory ☐ Burial 2 XX Cremation 3 ☐ Removal from State February 3, 4 Donation 5 Other (Specify) Odenton, Maryland Donaldson Funeral Home & Crematory, P.A. 1411 Annapolis Road, Odenton, Maryland 21113 Signature of Funeral Service Will Ell M00672 23a, Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph sician/ disease or condition av Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 X No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy 1 Yes 2 🗌 No Yes To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X 10 1 Department 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural 2 Accident 5 Pending 1 Yes 2 No Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

I Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check

24 hours after death.

2 Huneral Director. After this certificate hated filled in by the funeral director, pag. Medical Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the only one) 29b. Signature and title of certifier son who completed cause of death (I em 23a) (Type, Print) of p Day, Year) 32. Registra State FEB 0 7 2011 Registrar ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 18 per the 913 3-25-11 vt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 6=35 1ams 2011 dorugry Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rendall Sty If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** 1 X M 2 □ F Months Hours (Month, Day, Ye 10-29-1934 Director 216-30-5167 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits should be filed within 72 hours after death with the Maryland Director MD Baltimore Randallstown 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA Funeral 9109 Liberty Road 21133 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Completed by 1 Never Married 2 Married 1X Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: African-American "natural", 3 Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) DC Post Office Postal Employee Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Milton Burke Mabel Hill Dillard Knight 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roderick C. Knight Sr./Son 9928 Tuscamora Road, Randallstown, MD 21133 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Veterans 2-14-2011 Owings Mills, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Wile Funeral Home P.A. of Balto. Co. 9200 Liberty Road, Randallstown, MD 21133 Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, is bock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ stroin Medical Due to (or as a consequence of) Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of) within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Dav Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes 2 No 25. Was case referred to medical æ 26. Place of Death (Check only one) Other: မြ 1 Yes 2 **X**No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 2 🗌 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State Registrar

For State Registrar

			1. Decedent's Name (First, Middle, La	ast)					2	. Date of De Month	eath Day		ear	3. Time o	f Death		
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	be filed within 72 hours after death with the Maryland ttal Hygiene.  di other than "natural", or items 23a or 28a-f show event, the Mcdical Examinar nust be neithed at	Funeral	11. Marital Status	12. Was Deceden Armed Forces	t Ever in U.	S. 13. W	as Decedent of H	lispanic Orig	in? (Speci	fy Yes or No	o-			an Indian,			
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		D0069148 January 2								25	. 2011	L					
	./\	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)								•							
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

03067

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

			Pleas	se Type or F								_	le.		
		For State		State of	Marylar				lealth and	Mental Hy	giene	100	9	3068	
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Funeral		<ol><li>Social Security Nu</li></ol>	ımber 6		Age (In yrs. I		If Under Months		If Under 24 Hrs. Hours Min.	8. Date of Bir	th	9.	Birthpla	ace (State or Foreign	
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and show	ō	10a. State	10b. County		10c. Cit	ty, Town or L	ocation				-		10	d. Inside City Limits	
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s afte ral", c Exan	q pe	3 Widowed		If Yes, Give Year or Date			1  Yes 2	⊠ No	Specify:			Specify: \[	Vhit	.e	
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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Fut	neral Service Lice	_/ /	M01607									ille, Inc.	
		23a. Part 1. Enter the	ne disease, or co	omplications that cau	sed the deat							OCKVII.		MD 20850	
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Medical		resulting in death)  a. Due to (or as a consequence of):  Cachexia										+			
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To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the bu	Medical	29a. Certifier 1	Certifying P	hysician: To the bes	t of my know	ledge, death	occured at the	ne time,	date and place, a	ind due to the ca	iuse(s) ar	nd manner as	stated.		
he Ho in 24 he Fu ipleter	Med	(Check 2 only one) 3	<ul> <li>✓ Medical Exa</li> <li>✓ Certifying N</li> </ul>	miner: On the basis urse Practioner: To	of examination the best of m	n and/or inve y knowledge,	stigation, in m death occurre	y opinioned at the	n, death occurred a time, date and pla	at the time, date a ace, and due to th	and place ie cause(:	e, and due to t s) and manne	he caus r as stat	se(s) and manner stated. ed.	
North Corr		29b. Signature and t	itle of certifier	0		1	29c.		number		29d. Da	te signed (Me	onth, Da	ıy, Year)	
a.l		1/6	19 A	have	my			00	695	5	1/3	1/11			
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Stat	e	<ol> <li>Date filed (Month)</li> </ol>	, Day, Year)	M.D. 8808	strar's Signat	ture	Lane	Pot	omac, Ma	ryland	<u> 2085</u>	4			
Registra		FEB 07	2011	Enera &	. pa	Ker									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Sadie M. Keefer 2011 February  $p_M$ 1:40 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Atlantic General Hospital Berlin Worcester County Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 7. Age (In vrs. last birthday Min 1 □ M 2 🖾 F Months Hours 0870871914 Maryland 216-12-0919 Director 96 Usual Residence of Decedent show 10a. State r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director Shady Side MD Anne Arundel 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20764 4967 Elm Street United States 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. δ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 3 Midowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72? Department of Health and Mental Hygiene. Important: If feen 27 is marked other than "na any injury or other traumatic event "to once." (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Sales Clerk Retail Sales Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Rebstock Sadie Kestler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph D. Keffer (Son) 704 Hickman Drive, Ocean View, DE 19970 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ቖ Burial 2 🗌 Cremation 3 🔲 Removal from State Crestlawn Memorial 02/08/2011 Marriottsville, MD 4 Donation 5 Other (Specify) Si patu e of Funeral Servi e Licensee 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on such line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine if any leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events use as the burial-trar Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?
1 Yes 2 No Day Pregnant at time of death detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy erform To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate h ☐ Yes 2☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes ၉ Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28b. Time of 28d. Describe how injury occurred 1 🗶 Natural 5 Pending work? Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State, Medical Certify! P' sician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medi I E miner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier completed 2 Medic 1 E siminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Cerj in Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) 31. Date filed (Month, Day, Year 32. Regist State FEB 07 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Year **Physician** 63011 M EKILINA 4/1/60 /Medical 4a. Facility Name (If not Institution, give street and number) 4h City Town or Location of Death 4c. County of Death Examiner G 60.2501 2 leve 3 Crestille 0.0-31 bill 5 NUSSING autha 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1, M 2 □ F Director 04-29-1942 578-56-8649 SC Usual Residence of Decedent 10b. County 10d. Inside City Limits 10a. State item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Examination used on the confined at 10c. City. Town or Location Director N Yes 2 No Washington DC 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 201 58th Street, 20019 NE #039 Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 72 hours after 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No þ Specify. Specify: 3 Widowed 4 Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) filed within 7 I Hygiene. than Elementary/Secondary (0-12) College (1-4or 5+) 9th Cement Finisher Private Co is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be fi and Mental H Silas Littles Corine Mallard ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health em 27 is Albeny Littles (brother) 7007 Fairwood Rd, Hyattsville, Md. 20784 Department of Heal Important: If item 2 any injury or other 20a. Method of Disposition Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Pages 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery 01-28-11 Suitland, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licensee DC 20019 Dunn & Son Funeral Home 5635 Eads St, NE, Wash. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Quse (Final Physician ASOPHALINGORE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Examiner Due to for as a consequence of The law requires that the death certificate be executed burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): physician at the burial-Box 68760, Physician/Medical attending p for use as use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) P.O. the Tyes 2 No detached 9 Unknown ģ s been signed b should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No certificate has b irector, page 2 st 24a. Was an autopsy performed' 2 1No 1 □Yes or Attending Physician: 25. Was case referred to medical director Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 A Natural 5 Pending investigation thours after death.

uneral Director; Afely filled in by the fur 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical completely (Check only one) within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1160 Unin 71665 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ FEBRUARY 201 Tear :55P CHARLES EDWARD LINTON Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1 X M 2 - F Months Director 95 11. 1915 Indiana 304-03-1275 Feb. Usual Residence of Decedent 28a-f show 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 No Frederick Frederick Maryland 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? Funeral items 23a 21703 5820 Genesis Lane, #514 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ò 1 

Yes 2 □ No

If Yes, Give

Year or Dates. 1942–45 þ 72 hours after 1 ☐ Yes 2X No Specify: "natural" 3 ☑ Widowed 4 ☐ Divorced Specify: White Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) draftsman concrete structures Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ permit. Page 1 and 2 should be: Department of Health and Ments Important: If item 27 is marked Arthur Linton Mary Ann Hale 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas Linton/ son Walkersville, MD 21793 P.O. Box 188 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State injury ( 4 Donation 5 Other (Specify) Hope Cemetery 2/5/2011 Woodsboro, MD 21. Signature of Fureral Service Licer 22. Name and Address of Facility Hartzler Funeral Home atharine 404 S. Main St. Woodsboro, MD 21798 23a. Part 1. Enter the disease, or complications that used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) <u>Pneumonia</u> DAYS Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death. the Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death signed by the a d be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Dementia 1 ☐ Yes 2 Z No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No death? 1 Yes 2 No completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28a. Date of injury (Month, Day, Year) Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work? 5 Pending Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and place, and due to the cause Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 To the F 29b. Signature and title of certifie 29c, License number 29d. Date signed (Month, Day, Year) D32171 alalıı 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) po box 328 Walkersville, Md Richard Gough 21793 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

State Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 28,2011 Edith Lowery January 6:50pm Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Prince Georges 6100 Otis St Landovei If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthdav) 8. Date of Birth 9. Birthplace (State or Foreign Country) Unk Funeral Davs Min. (Month, Day, Year) 1 🗆 M 2 🕱 F Director 61 213-54-8917 3-21-1949 Usual Residence of Deceden Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ms 23a or 28a-f sho must be notified at Director Prince Georges Landover 1 Yes 2 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20785 Funeral 6100 Otis St "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 X No Specify: Specify: 3 ☒ Widowed 4 ☐ Divorced Year or Dates marked other than "natumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) food industry waitress unk unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Edith Bolton Stanley Foltz 19a. Informant's Name/Relationship (Type, Print) Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  $6103\ Osborn\ Rd;\ Landover,\ MD\ 20785$ Cecil Schwab - friend permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr once. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ※ Other (Specify) in state cemetery, crematory or other place) 21. Signature of funeral Service Licenses Ronal d S 22. Name and Address of Facility State Anatomy Board frector 655 W. Baltimore St; Baltimore, MD 21201 Pan 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Pitysician, CARDIAC L'AILURE disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Each Underlying Examine Due to (or as a consequence of) Cause (Disease or linjury that initiated events attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) signed by the atte in the past 12 months? Month Day Year Pregnant at time of death Unknown 2 70 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 14 Y DERSENSION 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should DIABETES . Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 🗌 Yes 2 🔲 No Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 A Residence 6 ☐ Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examining unit and investigation, it my opinion, beautiful and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) D0058290 31/2011

Registrar
DHMH 17 Rev 7/2009

State

Sarvix Ave. suite 200 Riverdale MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Muthath

5711

Sureshbumar

FEB 0

11-00305 Kevin S. Lewis

evin S. Lewis		State of Maryland / Department 1-For State Certificate Registrar		and	Menta	al Hygie		g. No. 2011	03073
Physici		Decedent's Name (First, Middle, Last)					ate of Death	n Day Year	3. Time of Death
edical Exami	ner	Kevin S. Lewis  4a. Facility Name (if not institution, give street and number)	4b. City, Tov	!-	antina of	Ja	nuary 11		0015 hrs
		University Hospital	Baltimo		cation of	Death		4c. County of Dear	31
Funeral		5. Social Security Numbe(ank) 6. Sex 7. Age (In yrs. last birthday)	If Under	1 Year Days	If Under 2			(MM/DD/YYYY) 9. B	an
Director		1⊠M 2□F 45	Yrs.	Days	Hours	""" Ma	rch 9	, 1965 <sup>Fore</sup> c	ountry)Virginia
any.		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Loc	cation				-		10d. Inside City Limits
		MD Baltimor							1 X Yes 2 No
Aarylan 28a-f sl	cto	10e. Street and Number	10f. Zip Co	ode			10	g. Citizen of What Cou	Intry?
MD 21215-0036 2 should be supplied the Maryland by and Montal Higgiene, the Thomas after death with the Maryland by and Montal Higgiene, and "matural", or items 23a nr 28a-f abu and the than "matural", or items 23a nr 28a-f abu matic event, the Medical Examiner must be notified at once	Director	820 N. Carey St; Apt 2	212	17				USA	
th with tems 2 st be n	Funeral	1 Never Married 2 Married Armed Forces?	Was Decedent f Yes, specify 0					14. Race - Ame White, etc.	rican Indian, Black,
ter deg		1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year	Yes 2 X	No :	specify:			Specify: b1	ack
ours af	d by	15. Decedent's Education (Specify only highest grade completed) 16a. Deced	ient's Usual Oc	cupation	n (Give kir		lone	16b. Kind of Business	/Industry
6 72 ho	lete	Elementary/Secondary (0-12) College (1-4 or 5+)	most of working	ig life. D	O NOT us	se retired)			_
5-0036 Thed within 72 Hygiene. d nther than	Completed	12 0 che	ef					food in	
21215-0036 Juld be filed within 7 Mental Hygiene, marked nither than	Be Co	17. Father's Name (First, Middle, Last) $unk$		18	.Mother's	Name (Firs	t, Middle, M	aiden Surname)UNK	
2121 hould be fi and Mental I is marked	5		•					per, City or Town, Stat	
imore, MD 2 Pages 1 and 2 shou ment of Health and 1 Int: If item 27 is no retor traumatic		Shawn Peterson - stepbrother 272  20a. Method of Disposition 20b. Place of Disp				Bal Dat		e, MD 2121	
Baltimore, permit. Pages 1 an Department of He Important: If ite	Ш,	1 Burial 2 Cremation 3 Removal from State crematory or		01 001110	iory,	Dat		200. Education - Only o	Town, otate
fim Pagrithment ortant:		4 Donation 5 X Other Specify: in state	Name and Ad	Idress of	Eacility	Ctata	Anat	omy Board	
Baltimore, M permit. Pages 1 and 2 Department of Health Important: If item 2 injury nr other traus		21. Signature of Funeral Service Licensee Roma Id S. Wade, Director						timore, MD	21201
Physician		23a. Part I Enter the diseas., or complications that caused the death. Do not ente failure. List only one cause on each line.							Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (Final disease a. Gunshot Wound of Torso							Death
		or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions,  b.							
	iner	if any, leading to immediate cause. Enter Underlying Cause  Due to (or as a consequence of):							
ted nsit	Examiner	(Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):						· -	
68760, certificate be executed nding physician and se as the burial - transit	edical	d.  UNPENDED AMENDED							
760 icate b physi		IF FEMALE: 23b. Was decedent pregnant in the			1			23d. Date of deliver	
Box 6876 death certificate he attending phy	cian	past 12 months?	Fetal death Other (Specify)		Ectopic p	regnancy		Month	Day Year
BOy e death the att	Physician/N	1 Yes 2 No 9 Unknown 9 Unknown	Office (Opcomy)						
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ords,   w requires s been sig should be		I				— III	24a. Was ar		utopsy findings available
COT law re has be	Completed					-	autops: perform		completion of cause of
tal Reco		25. Was case referred to medical	26.1	Ologo of	Death (CI	heck only o	Yes 2	No 1 ✓ Y	es 2 No
/ital	Be	examiner? Hospital: 1 Innetion 2 FR/Outpetie		I O t	<u> </u>	lursing Hon	<del></del>	tesidence 6 Othe	n.
n of Vital ing Physician: After this certif	5.7	27. Manner of Death 28a. Date of Injury (Month Day Year)	of Injury 28c	. Injury a	at Work?			ow injury occurred	
ision Attendii rector: A by the fu	aţio	1 Natural 5 Pending FOWND: Day Year) 2 Accident Investigation Jan 10, 2011 2341 hrs	1	Yes	2 🗸 N	o Subj	ect shot		
Division of Vital Records, rather Attending Physician: The law requires and the death. After this certificate has been side in by the funeral director, page 2 should be in by the funeral director, page 2 should be a second the death of the funeral director, page 2 should be a second the death of the funeral director, page 2 should be a second the death of the funeral director, page 2 should be a second the death of the funeral director, page 2 should be a second the death of the de	Certification:	3 Suicide 6 Could not be	reet, factory, of	fice buil	ding, etc.		or Town, Sta	ate)	ural Route Number, City
Tie of Pi		29a. Certifier		a det	and -1			ollton Avenue, Balti	
To the Hos within 24 h To the Fur completely	Medical	one)  1 Certifying Physician: To the best of my knowledge, death occurrence only  2 Medical Examiner: On the basis of examination and/or investige and manner stated.							
To witi	¥	29b. Signature and title of certifier	29c. Li	icense n	umber			29d. Date signed (Mo	nth, Day, Year)
		higher. V.	0	D.C.M.	E.			January 11, 201	1
		Name and address of person who completed cause of death (Item 23a)     Ling Li, MD	ore Street	Raltim	ore Mr	7 21222			
	ate			Jaillill	IOIE, IVIL	J Z 1ZZ3			
Panie		31. Date filed (Month, Day, Year)  See 1. Registrar's Signature  2. Registrar's Signature	Ker						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Mackin Stephen Patrick 1300 2011 Medical 4a. Facility Name (if not institution give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of 1708/1tm slumbia ounh General 000 Sex **O** 1 **X** M 2 □ F 8. Date of Birth (Month, Day, Year) Dec. 7, 1950 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Months Days Min. Hours Country) 207-42-1622 Director 60 PA Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🛣 No Howard Columbia MD 10e. Street and Number 0 10f. Zip Code 10g, Citizen of What Country? be Funeral ıral", or items 23a Examiner must b 10701 Judy Lane 21044 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 ☒ No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 "natural". If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: white Completed 3 Widowed 4 Divorced other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Marketing Manager Verizon Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Ann McGuire <u>Stephen Patrick Mackin, Sr.</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10701 Judy Lane, Columbia, MD 21044 Donna K. Mackin/ wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State  $\texttt{Feb.12}^{\texttt{Date}}$ 1 🛮 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maple Grove Cemetery 2011 Vermilion, OH Signature of Funeral Service Licensee 22. Name and Address of Facility Donaldson Funeral Home, P.A. Ken Skilo 313 Talbott Ave., Laurel, MD 20707 M01053 23a. For 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, snock, or heart failure. List only one cause area h line. Interval Between Coronary Vessel disease Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to for as a consequence of, the attending physician and hed for use as the burial-transit Cause (Disease or linjury that initiated events or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: After this certificate has been signed by the attendin funeral director, page 2 should be detached for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Year Pregnant at time of death Day 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably Unknown bid obesity, in fibrillation 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed within 24 hours after death.

To the Funeral Director: After this certificate ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဂ 1 Yes 2 No 1 Inpatient 2 PR/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred injury 1 Natural 5 Pending 1 Tes 2 🗌 No Accident Investigation filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: Tyrthe begret my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature and title 2 completed cause of death (Item 23a) (Type, Print) 5755 adarlane 31. Date filed (Month, Day, Year)
FEB 0 7 2011 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Fe b Day MIKOLOSKI 7:30 0 2011 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death Examiner 4c. County of Death of Maryland Medical Center Baltimore University Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country)
 MD **Funeral** 8. Date of Birth Feb. 26, 1 🗆 M 2 ⋤ Hours Min 1952 Director MD 218-56-7921 58 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10c. City. Town or Location 10d. Inside City Limits Director MD Carrol1 1 🗆 Yes 2 ី No Sykesville 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 6494 KenMar Drive 21784 USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 Never Married 2 X Married Completed by ☐ Yes 2 🏋 No Yes, Give Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Health and Mental Hygiene, tem 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Teacher's Assistant Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ J. Evans Walter Patricia Ann Nix 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Edward W. Mikoloski (Spouse) 6494 KenMar Drive Sykesville, MD 21784 permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other i Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2/6/2011 All County Cremation | Sykesville, MD Signature of Funeral Service License 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PO Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Breast Onset and Death Physician Cancer disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and I for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) in the past 12 months? Ectopic pregnancy Month Day Year Pregnant at time of death signed by the at d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 🗶 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perforr death? eral Director: After this certificate ifilled in by the funeral director, pag 1 Yes 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 힏 2 No Other: 1 Impatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide 5 Pending injury 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a To the Funeral I Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

104

State Registrar 31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Sig

06565

3rd

Baltimore,

2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) For State Registrar Certificate of Death Reg. No. Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Physician/ Feb. 3° 201 Tea 5:20 PM Granville Evans MacCallum Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gladin Road Annapolis Anne Arundel Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Funeral Min. 1 X M 2 🗆 F Hours Month, Day, Year) 6/18/1915 95 Director 212-07-5535 MD Usual Residence of Decedent show 10a, State 10c. City, Town or Location injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director 28a-f 1 ¥ Yes 2 ☐ No MDAnne Arundel Annapolis ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Completed by Funeral 5 Gladin Road 21401 USA items 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces 0 1 Never Married 2 Married 2 No WWII 1 X Yes If Yes, Give 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: Page 1 and 2 should be filed within 72 hours aft ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", Specify: White 3 Widowed 4 Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Building Inspector Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ڡ Alexander MacCallum Bessie Lucas 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gladin Rd, Annapolis, MD 21401 Florence MacCallum (wife) 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Department of H Important: If ite cemetery, crematory or other place) 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2/7/2011 Glen Burnie, MD Atlantic Crematory . Signature of Funeral Service Licensee 22. Name and Address of Facility Hardesty Funeral Home 12 Ridgely Ave Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to for as a consequence of attending physician and for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Dav the 9 Unknown 9 Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? After this certificate ! 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 2 No 1 Tes ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 hesidence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 24 hours after death. Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: Ai
completed filled in by the fu 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

2x

Box 68760

P.O.

Division of Vital

State Registrar

31. Date filed (Month, Day, Year)

completed cause of death (Item 23a) (Type, Print)

Tokwatcu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <sup>Day</sup>, 2011 Katherine Ford Magurn February 10:45 P M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery Germantown 14700 Berryville Road | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Min. | July 18, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Months 1 □ M 2 🖺 F 226-03-2029 96 Virginia Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Germantown Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 20874 14700 Berryville Road 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify. White 3 ☐ Widowed 4 ☑ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Linguist Language 5+ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Armistead Ford Anna Allen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2308 Glenmore Terrace, Rockville, Maryland 20850 Katherine F. Magurn/Daughter 20b. Place of Disposition (Name of Montgomer States) 20a. Method of Disposition Date 20c. Location - City or Town, State February 7, 1 ☐ Burial 2 ICCremation 3 ☐ Removal from State 2011 Crematorium, Inc. 4 ☐ Donation 5 ☐ Other (Specify) Bethesda, Maryland 21. Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Ave., Rockville, MD 20850-2805 M00198 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Congestive Heart Failure Years Due to (or as a consequence of): Years Hypertension Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1☐ Yes 2 🖾 No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Atrial Fibrillation 1 Yes 2X No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? /es 2 No

1□ Yes

Other: 4 Nursing Home 5 \ Residence 6 Other (Specify)

28d. Describe how injury occurred

29d. Date signed (Month, Day, Year)

February 4, 2011

26. Place of Death (Check only one)

Physician /Medical Examiner

Physician

/Medical

**Examiner** 

Director

Funeral

Completed by

Be

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

Examine burial-trar Physician/Medical the for use

and attending physician detached à page 2 should this

ģ

Completed

Be

25. Was case referred to medical examiner?

5 Pending investigation

1 ☐ Yes 2 X No

27. Manner of Death

1 XNatural

2 Accident

Physician: The law requires that the death certificate be executed funeral director, After t death.

Division or Vital Records, P.O. Box 68760, Hospital or Attending after death Director:

Certification: To 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a 29a. Certifier (Check or one) 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2 29c. License number 29b. Signature D19294 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 911 Russell Avenue, Gaithersburg, Maryland R. Melnick, M.D. 31. Date filed (Month, Day, Year) State Registrar

1 Inpatient

28a. Date of Injury (Month, Day Year)

2 ER/Outpatient 3 DOA

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28b. Time of Injury

			Please Typ							_	_	le.	
			For State Registrar	tate of Ma	ryland				lealth and Death	Mental Hy	giene Reg. No. U		3078
	Physic	ian	1. Decedent's Name (First, Middle, Last)							2. Date of De		Year	3. Time of Death
200	/Medi			sther Ma	e Mu	rphy				Janua	-		7:40PM M
	Examir	ner	4a. Facility Name (If not institution, give stree	,			4b. City,		r Location of Deat		4c. County of	Death	
<b>M</b> 3"	Funeral	_	Rockville Nur:  5. Social Security Number 6. Sex			st birthday)		r 1 Year			rth M	<ol><li>Birthpla</li></ol>	omery ace (State or Foreign
н	Director		316-26-0208 <sup>1□ M</sup>	2[ <b>X</b> F	84	Yrs.	Months	Days	Hours Min.		er 4, 1926	Count Ir	ndiana
	pug 🔌	1	Usual Residence of Decedent  10a. State 10b. County		10c City	Town or Lo	cation			1			d. Inside City Limits
	the Marylar 28a-f show	ō			Toc. Only,	TOWIT OF LO	batton						1 ☐ Yes 2 📉 No
	the l	Director	Maryland Montgon  10e. Street and Number	nery			10f. Zij		arnestow	n	10g. Citizen of Wh	at Count	ry?
	72 hours after death with the Maryland 'natural', or items 23a or 28a-f show dical Eveniner must be notified at	al D	12801 Ter	n Drive					20878		Uni	ted	States
	ems	Funeral	11. Marital Status	Was Decedent E		. 13. V	Vas Dece f Yes, spe	dent of F	lispanic Origin? (S an, Mexican, Puer	Specify Yes or No to Rican, etc.)			ın Indian,
36	s afte	by Fu	77	1 ∐Yes 2 [ <b>X</b> No If Yes, Give Year or Dates:	D		□Yes		Specify:	,	Specify:	, , ,	-
5-0036	hour	edk	15. Decedent's Education			16a. Deced	lent's Usu	ıal Occur	ation		16b. Kind of Bus		hite ustry
215	e. Bu"na Medic	plet	(Specify only highest grade co.	mpleted) College (1-4or 5+	<del>,  </del>	(Give		ork done	during most of wo	rking			,
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nd	be file	Be	17. Father's Name (First, Middle, Last)						18. Mother's Nar	me (First, Middle	, Maiden Surname,	1	
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ē,	f Hea f Hea item 2	-	Maureen M. Danforth, 20a. Method of Disposition	Daugnt	20b. Pla	ce of Dispos	sition (Na.	me of	-)	Date	Virgini 20c. Location - C		
E O	Pages nent o nt: If i		1 ☑ Burial 2 ☐ Cremation 3 ☐ Remo 4 ☐ Donation 5 ☐ Other (Specify)	oval from State	A1	metery, crem rlingt ationa	on Con	otner piac	Febr	uary 8, 011	Arlingt	on.	Virginia
Baltimore,	permit. Departm Importa any inju		21. Signature of Funeral Service Licensee	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	1 110	22	. Name a	nd Addre	ss of Facility Ro		Pumphrey	Fun	eral Home/
<u>m</u>	8 9 E 8 8			Jestant	M003	35	Rock Rock	vill	e, Inc. e, Maryl	300 Wes and 208	6 Montgom 50-2805	ery .	eral Home/ Avenue
			23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one care	ons that caused t ause on each line	the death.								Approximate Interval Between Onset and Death
-	Physician		Immediate Cause (Final disease or condition resulting in death)	Hyperte	ensiv	e Hear	rt Di	iseas	se			j	Onset and Death
4	/Medical Examiner		resulting in deality	Due to (or as a		·							
		ē	Sequentially list conditions, if arry, leading to immediate cause. Enter Underlying Cause (Disease or injury	Coronar			ıseas	se					
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O.	that the de ned by the detached	Jysi		9 Unknown		u 0 _	other (s	peany) _					
о, С	s that med b	by Pi	Part II. Other significant conditions contribe	uting to death but	not result	ing in the ur	derlying o	cause giv	en in Part I.	23e. Did	tobacco use contrib	oute to the	e cause of death?
of Vital Records,	w requires been sign should be	pa	Cerebrovascular A	ccident						1 🗆	Yes 2 □ No 3	B□ Proba	ably 4 🔁 Unknown
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<u>~</u>	The cate ha	Completed								perfe 1 □ Yes	ormed? de	ath? ⊒Yes :	
Vit.	Physiclan: Th this certificate ral director, pag	B	25. Was case referred to medical examiner?	ital:				OA Oth		ath (Check only			
	Phys r this ral dir	<u>۲</u>	I les ZIVINO	1 ☐ Inpatien		R/Outpatien 28b. Time of			4 EN Nursing i		idence 6 Other		)
on	Attending Ph r death. ector: After th by the funeral	tion	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day,	Year)	Injury	м	28c. Inju Wor 1 🏻	k?¯` Yes 2 □ No	200. 20001120	The Wingery Coodings		
Division	I or Attend after death. Director: /	Certification:	a Double 6 Double not be 1	8e. Place of Injur	y - At hom	ne, farm, stre	et, factor	y, office			(Street and Number	or Rural	Route Number,
Ö	pital or At ours after c eral Direc filled in by	Cert	4 [] Hornicide	building, etc.	(Specify)					City of To	wn, State)		
	Hospital 24 hours a Funeral letely filled		29a. Certifier 1	On the basis of	examinatio	ledge, death on and/or in	occurred vestigation	d at the ti n, in my o	me, date and plac ppinion, death occ	e, and due to the urred at the time	e cause(s) and mar , date and place, ar	ner as st	ated. the cause(s)
	To the Hos within 24 ha To the Fun completely	Medical	one) 29b. Signature and title of certifier	and manner state	ed.		29	c. Licens	e number		29d. Date signed	(Month, [	Dav. Year)
	F > F 8		Moinno	V. 90:	san L	1			D/7000				
	15V		30. Name and address of person who compl	eted cause of dea	ath (Item 2	23a) (Type. I	Print)		D47330		Janua	ry 1	9, 2011
	1		Thomas V. Joseph. 1	M.D. 50	West	Edmor	·	Dri	ve, #207	, Rockv	ille, Mar	ylan	d 20852
	Sta		31. Date filed (Month, Day, Year)	32. Registrar	r's Signatu	re							
	Registr	ar	FEB 0 7 2011 Dener	7 7.1	7								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 14 AM LVEY Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death County of Death ontgomer Adven Gruva ad Age (In yrs. last birthda If Under 1 Year If Under 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 □ M 2 👿 F Months Days Min. Director Usual Residence of Decedent or 28a-f show 10b. County 10a. State 10c. City, Town or Location any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Ves 2 No -/a. KR a 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a Funeral 3801 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Black Completed 3 Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working lifg. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malder ဂ Latri 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 25 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signater of Funeral Service Licensee Jou 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to for as a consciuence of if any leeding to immedia cause. Enter Underlying Cause (Disease or iinjury The law requires that the death certificate be executed attending physician and for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No been signed by the atte should be detached for Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No death? 1 ☐ Yes 2 ☐ No Division of Vital the Hospital or Attending Physician: To Be 25. Was case referred to medical completed filled in by the funeral director, 26. Place of Death (Check only one) 1 \( \text{Yes} \) Other: 2 No 1 ■ Inpatient 2 □ ER/Outpatient 3 □ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manne Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at To the Hospital or Attending P within 24 hours after death.

To the Funeral Director: After it 28d. Describe how injury occurred 5 Pending ✓ Natural injury work? 2 🗌 No Accident Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0068178 FEBRUARY, 04, 2011 30. Name and address 🌢 person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year,

gistrar's Signature

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		Plea	ase Type or Pi					_	_	jible.	
		For State	State of N	/larylan		artment of F		Mental Hy	giene		
	_	Registrar  1. Decedent's Name (First, Middle	/ act)		Cer	tificate of L	Death	<del></del>	Reg. No.	100	1080
Physicia		Fred Her	,	Cr	-			2. Date of Dea Month Februar		Year	3. Time of Death
Medic Examin		4a. Facility Name (if not institution		ey, Sr	•	4b. City, Town, or	r Location of Death	1 CAST WELL	4c. County		1 , , , , ,
		Penidsula Regio	MAL Hedica	Z Ci	enter	540	4/3/214		1/1	cons	20
Funeral		5. Social Security Number 215–36–8348	6. Sex		ast birthday) Yrs.	If Under 1 Year Months Days	It Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da	th (0,1920	Cour	iplace (State or Foreign ntry)
Director s		Usual Residence of Decedent		91	115.			Jan. 3	1920	Ma	aryland
/land f shov	tor	10a. State 10b. County		10c. Cit	y, Town or Lo	cation	-				10d. Inside City Limits
e Man r 28a- notifie	Direc	4	ederick				Airy				1 Yes 2 XNo
ith th	ral	10e. Street and Number 8302 Maple	willo Pd			10f. Zip Code	217	771	10g. Citizen of		intry?
eath w	Funeral Director	11. Marital Status	12. Was Decedent		S. 13. \	Was Decedent of Hi	ispanic Origin? (Spe	ecify Yes or No-	14. Rac		can Indian,
fter de ", or if amine	by	1 Never Married 2 Marr	If You Give			f Yes, specify Cuba 1 □ Yes 2 🛣 No		Rican, etc.)	Blac Specify	ck, White,	etc.
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n 72 h an "na Medic	mpl		est grade completed)	- F.\	(Give	kind of work done o O NOT use retired)		ing	16b. Kind of B	usiness In	dustry
withir rgiene her tha		11	College (1-4 or	3+)		farme	r			dairy	7
e filed Ital Hy ed oth	To Be	17. Father's Name (First, Middle, L	,				18. Mother's Nam			*	
d Mer mark		Ernest Walte			Tage 14 m	~			beth Co		
12 shouth an 27 is reau		Fred H. Moxley				ng Address (Street a			n, MD 2		Code)
1 and of Hea fitem		20a. Method of Disposition			Place of Dispo	sition (Name of natory or other place		Date	20c. Location		own, State
Page ment cant: If ant: If		1 🔀 Burial 2 □ Cremation 4 □ Donation 5 □ Other (S				r's Cemet	:	/2011	Liberty	town	, MD
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Fureral Service L	ice (See )	5Pen	, 22	. Name and Addres	ss ot Facility Ha	rtzler I	Funeral	Home	
HH = (6 O)		23a. Part 1. Enter the disease, or	complications that cause	od the deat		1802 Lib	-		tytown,	MD 2	21762 Approximate
Physician/		shock, or heart failure. List of Immediate Cause (Final		ne.		_					Interval Between Onset and Death
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ed sit	Examiner	it any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	Due to (or a	s a consequ	uence of):						
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or Attending Physician: The law requires that the death certificate be after death.  Director, After this certificate has been signed by the attending physic in by the funeral director, page 2 should be detached for use as the bi	/Med	IF FEMALE:	00- 16								
sath certifica attending p	cian	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom  1  Live Birth 4  Pregnant	2 🗆 Feta	aideath 3 🗆	Ectopic pregnanc Other (specify)	sy .			ite of deliv onth	very Day <b>Ye</b> ar
the dea by the a tached	hysi	1 Yes 2 No 9 Unknown	9 Unknown			z diner (opeany)					
s that i	by P	Part II. Other significant condition	ns contributing to death	but not res	ulting in the u	inderlying cause giv	en in Part I.	23e. Did to	obacco use cont	ribute to t	he cause of death?
v requires the specific specific specific specific should be a specific should be a specific								1 🗆 '	Yes 2 No	3 🗌 Pro	obably 4 Unknown
law re has b	Completed							24a. Was autop	osy		opsy findings available ompletion of cause of
sician: The la certificate ha irector, page 2		25. Was case reterred to medical			_	00 8:	15 11 (0)	1 🗌 Yes		1 Yes	2 🗆 No
ysicia is certi directo	To Be	examiner? 1  Yes 2 No	Hospital:	ntient 2 🗆	ER/Outpatier	Othe	er:		dence 6 🗆 Othe	er /Specifi	iv)
ding Phys th. After this funeral di	te: 1	27. Manner of Death  1 Natural 5 Pendin	28a. Date of in	jury	28b. Time of injury		/ at		ow injury occurr		9
death. death. stor: Af y the fu	ifica	1 Natural 5 ☐ Pendin 2 ☐ Accident Investig 3 ☐ Suicide 6 ☐ Could	gation			M 1 🗆	Yes 2 □ No				
I or Attend after death Director; A d in by the f	Certificate:	4 Homicide determ	inad 28e. Place of in	njury - At ho etc. (Specify	ome, tarm, stre	eet, tactory, office		28f. Location (S City or Tow	Street and Numbe vn, State)	er or Rura	l Route Number,
To the Hospital of within 24 hours at To the Funeral D completed filled in	Medical	29a. Certifier 1 Certifying	Physician: To the best of	ot my knowi	ledge, death o	occured at the time,	, date and place, an	d due to the car	use(s) and mann	er as state	ed.
he Ho lin 24 he Fu npleted	Med	(Check 2 Medical E	Nurse Practioner: To the	examination	n and/or invest	tigation, in my opinic	on, death occurred a	t the time, date a	ind place, and due	e to the ca	ause(s) and manner stated.
Voirt Con Con		29b. Signature and title of certifier				29c. License	number		29d. Date signed	d (Month,	Day, Year)
		20 Name and address of	who no data data d	dooth /li-	22a) /T: = - T				21514		
3√		30. Name and address of person v					ST. 3	544564	ing mo	21	801
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Registra	ir 💮	1 EU V (	ZUII LANGO	0000	W. 160 6	VIVE -					

				epartment of Health and N	lental Hyg	jiene	20001
			Registrar  1. Decedent's Name (First, Middle, Last)	Certificate of Death	T	Reg. No.	<u> </u>
Н	Physicia		Ernest Moore		2. Date of Dea Month	Day Year	3. Time of Death  2346 M
india.	Medio		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	01	25 Jell 4c. County of Dea	
			Seningula legional medical (enti	Salishur		laticon	oico
	Funeral		5. Social Security Number unk 6. Sex	Months Days Hours Min.	8. Date of Birth	9. Bi	rthplace (State or Foreign
	Director		Usual Residence of Decedent		Dec 28,	T941   Ma	ryland
	and show	or	10a. State 10b. County 10c. City, Town of	Location			10d. Inside City Limits
	Maryl 28a-f stiffied	rect	MD Wicomico Salisb	ıry			1 ☐ Yes 2 No
	h the	al Di	10e. Street and Number	10f. Zip Code		10g. Citizen of What C	ountry?
	th wit	Completed by Funeral Director	105 Times Square	21804		-	
<b>'</b> 0	or ite	y FL	11. Marital Status 1nk 12. Was Decedent Ever in U.S. Armed Forces?  1 □ Never Married 2 □ Married 1 □ Yes 2 No	<ol><li>Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto</li></ol>	ecity Yes or No- Rican, etc.)	14. Race - Am Black, Whi	te, etc.
98	rs afte iral", Exan	ed b	3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 🏝 No Specify:		Specify:	olack
5-0	2 hou "natu adical	plet		cedent's Usual Occupation unlive kind of work done during most of work	ina	16b. Kind of Business	Industry un
121	thin 7 ane. <b>than</b> he Me	Som	Elementary/Seconday (0-12) College (1-4 or 5+)	p. DO NOT use retired)			
д 2	led wi Hygid other ent, t	Be (	unk unk   unk   17. Father's Name (First, Middle, Last) unk	18. Mother's Name	e (First, Middle, N	Maiden Surname) 11	nk
/lan	d be fi Jental Irked Itic ev	입				<b>4</b>	
Baltimore, Maryland 21215-0036	ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at			ailing Address (Street and Number or Rura			p Code)
€,	and 2 fealth im 27 her tr			18 Lakeview Dr; Sal	isbury,	MD 21804	
) 0 1	Page 1 ament of Hament of Hament: If ite		1 Burial 2 Cremation 3 Removal from State cemetery,	sposition (Name of crematory or other place)	Date	20c. Location - City o	Town, State
≣	permit. Page 1 Department of Important: If i any injury or conce.		4 □ Donation 5 ☒ Other (Specify) In state	22. Name and Address of Facility St	ato Anat	omy Roard	
Ba	Depi Impo any		21. Sign peral cel ensee Wade irector	655 W. Baltimore		•	21201
н			23a. Part 1 Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.				Approximate
	Physician,	W 1	Immediate Cabse (Final disease or condition				Interval Between Onset and Death
	Medical Examiner		resulting in death)  a. Due to (or as a consequence of):				
	LAGITIME	-	Sequentially list conditions, b.				
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09	death certificate be executed ne attending physician and ed for use as the burial-transit	dical Examiner	d				
6876	tificat ing ph	Mec	IF FEMALE:				
9 X 6	ith cer	ian/	23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death	3 Ectopic pregnancy		23d. Date of de Month	livery Day Year
. Box		Physician/Me	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 9 ☐ Unknown	5 Other (specify)		World	Day You
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<u>&gt;</u>	Phys r this eral dii	요 :	1 ☐ Yes 2 ☐ No ☐ Hospital: ☐ Inpatient 2 ☐ ER/Outp.  27. Manner of Death	tient 3 □ DCA 4 □ Nursing Ho		nce 6 Other (Spec w injury occurred	cify)
on C	nding ath. :: Afte e fune	icat	Matural 5 ☐ Pending (Month, Day, Year) injute 2 ☐ Accident Investigation		zou. Describe no	w injury occurred	
Division of	r Atte er der rector	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office		reet and Number or Ru	ral Route Number,
S	urs aff				City or Town		
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director After this certific completed filled in by the funeral director,	Medical	29a. Certifier (Check 2 Medical Examiner: On the bast of my knowledge, dea	estigation, in my opinion, death occurred at	the time, date and	d place, and due to the	cause(s) and manner stated.
	o the	Σ	only one) 3 Certifying Nurse Practioner: To the best of my knowledges. Signature and title of certifier	e, death occurred at the time, date and place 29c. License number		cause(s) and manner as 9d. Date signed (Mont	
	->-0		) year	1563199		1/26/11	. ,
			30. Name and address of person who completed cause of death (Item 23a) (Typ	Print)	04 6: :		
				SHORE DL., SALI	SBUKY, M	P, 21864,	
	Stat Registra	e ir	31. Date filed (Month, Day, Year) 32. Registrar's Signature FEB 0 7 2011	Ked			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February Day 2 Angela Jean McLain 20°11 9:53 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death
Baltimore Timonium Stella Maris Social Security Numbe 7. Age (In yrs. last birthday) 62 yrs. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 214-52-9241 Months Days 1 □ M 2 🛣 F Hours Country) Director MD Usual Residence of Decedent 28a-f shov with the Maryland Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Harford Jarretsville MD 1 Yes XXNo 10f. Zip Code 21084 ō 10g. Citizen of What Country? Funeral 1427 Dalewood Drive 23a items ; hours after death 12. Was Decedent Ever in U.S 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc "natural", or by 1 Never Married 2 Married Yes 2 XNo 21215-0036 If Yes, Give Year or Dates 1 Tes 2 No Specify White Specify: 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 1 2 College (1-4 or 5+) d Mental Hygiene. marked other tha Daycare provider Services Be filed Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Clara Jean Barnett and Mental F Charles ပ Janson 19a. Informant's Name/Relationship (Type, Print)
Todd D. McLain / Son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trainonce. 21009 2612 Laurel Valley Garth, Abingdon, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Page 1 1 Burial 2X Cremation 3 Removal from State Final Journey Crem. 2/6/2011 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Maryland Cremation Services
PO Box 1413, Baltimore, MD 21. Signature of Funeral Service License Sprota Marshal 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition COLON CANCER Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Due to for as a consequence of cause. Enter Underlying Cause (Disease or iinjury that initiated events Exami attending physician and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ Month Day Year Pregnant at time of death sate has been signed by the page 2 should be detached □ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Yes 2 X No Division of Vital the Hospital or Attending Physician: hin 24 hours after death. filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 🗶 No 1 Tyes မ this 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 X Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Director; After 1 X Natural iniury work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b, Signature and title 29d. Date signed (Month, Day, Year) person who completed cause of death (Item 23a) (Type, Print) JACKIE JONES, CRNP 2300 DULANEY VALLEY RD.

DHMH 17 Rev 7/2009

State Registrar

FEBRUARY

ANGELA

egistrar's Signatur

TIMONIUM,

MD 21093

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 04 201 Year Feb. 0245 Thaddeus Felix Nalepa Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Annapolis Anne Arundel Anne Arundel Medical Center Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1**★** M 2 □ F Min. Hours (Month, Day, Year / 10 / 1935 Director 063-28-7639 7.5 Usual Residence of Decedent ms 23a or 28a-f shov must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Gambrills 1 ☐ Yes 2 X No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 978 Annapolis Road 21054 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter any injury or other traumatic event, the Medical Examiner. Black, White, etc Completed by 1 Never Married 2 Married □ No 1 Yes 2 □ No If Yes, Give 55-81 Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify: Specify: White 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Officer US Army Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F is marked o 2 Clara Fial Felix Rose Anthony Nalepa 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 978 Annapolis Rd, Gambrills, MD 21054 Karen Ryan (daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 2/6/2011 Glen Burnie, MD 22. Name and Address of Facility Hardesty Funeral Home 21. Signature of Funeral Service Licensee 2.0 851 Annapolis Rd, Gambrills, MD 21054 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Cardiac Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death. the Funeral Director: After this certificate has been signed by the attending physician and mobiled filled in by the funeral director, page 2 should be deteched for use as the burial-transit physician and the burial-transit that initiated events resulting in death) Last Physician/Medical as the l 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy5 Other (specify) \_\_\_\_ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No Yes 2 N 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 No 1 🗌 Yes ၉ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending work? 1 ☐ Yes 2 🗆 No 2 Accident 3 Suicide 4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Box 68760 P.O. Records, Division of Vital completed filled in by To the Hospital o within 24 hours at To the Funeral D

X State

Registrar DHMH 17 Rev 7/2009

only one 29b. Signature and

FEB 0

Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

fense Hmy, Crotton, MD 21114

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Januar Physician/ Day 6:14An crou Medical 2011 4a. Facility Name (if not institution, give street and number **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Bon Baltmore HESPI tay 8. Date of Birth (Month, Pay, 9. Birthplace (State or Foreign Country) Number 9799 Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Funeral 220 1 M 2 D F Hours Months Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If frem 27 is marked other than "natural", or iteme 200 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore 1 Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21216 USA 12. Was Decedent Eyer in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian. Armed Forces' Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2
If Yes, Give
Year or Dates. 1 Yes 2 No Specify: Specify Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b Kind of Business Industry (Specify only highest grade completed) eçonday (0-12) College (1-4 or 5+) Cleaner Be 17 Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ၉ Nance ames Harns 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nance 6022 RD A-2 Markita berwood Balto. Mo 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State grematory or other place, 1 Burial 2 Cremation 3 Removal from State cemetery, 4 ☐ Donation /5 ☐ Other (Specify) 21. Signature of Juneral Service Lice Name Home P.A. eral 23a. Part 7. F te/the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, 7 r leart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate use (Final disease or condition Physician/ venty Medical resulting in death) **Examiner** Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or linjury that initiated events Drie to (or as the attending physician and thed for use as the burlal-transit the Hospital or Attending Physician: The law requires that the death certificate be executed 10 erten Due to (or as a consequence of resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the care the Funeral Director financial director, page 2 should be detached it. 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 🗌 No 3 🗍 Probably 4 🕰 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 N 2 **Z**No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 🗆 No Other: ၉ 1 Inpatient 2 SR/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Accident
Suicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) Attending Cost, mo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar DHMH 17 Rev 7/2009 Cort, M.D

31. Date filed (Month, Day, Year)

Theer

W. Baltman

Bon Sesours Hospital

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ EORGE Month Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel 1453 Washington Avenue Severn 7. Age (In yrs. last birthday) If Under 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number **Funeral** 1 M 2 - F Months Days Hours Min. 01-15-192 Director 403-14-3720 90 Kentucky Usual Residence of Decedent 28a-f show 10a. State 10b. County 10d. Inside City Limits ms 23a or 28a-f shor must be notified at death with the Maryland 10c. City. Town or Location **Funeral Director** 1 Tes 2 X No MD Anne Arundel Severn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 1453 Washington Avenue 21144 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces Black, White, etc. include to more and Mental Hygiene.
Is marked other than "natural", or i þ 1 Never Married 2 Married 1 X Yes 2 If Yes, Give Year or Dates 2 No filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 ₩ Widowed 4 □ Divorced Completed White 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) United States Army 8 Sergeant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Page 1 and 2 should be 1 ment of Health and Menta Sylvester Osborne Rhoda Moore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau once. Mark J. Osborne / Son 1453 Washington Avenue Severn, Maryland 21144 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery crematory or other place)
Arlington
tional Cemetery 1 🛮 Burial 2 🗆 Cremation 3 🗀 Removal from State Arlington, Virginia 4 Donation 5 Other (Specify) 03-29-2011 22. Name and Address of Facility
Donaldson Funeral Home & Crematory, P.A.
Donaldson Funeral Home Maryland 21113 21. Signa Funeral Service art 1. Inter the disease, or complications that cause of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, but it is a failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ RONAR disease or condition resulting in death) Medical o (or as a consequence o **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): physician and the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 1 Yes 2 9 Unknown 2 No ed by the a detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? To Be Completed by 1 Yes 2 No 3 Probably 4 hknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🗆 No 24 1 Tes Yes To the Hospital or Attending Physician: Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 2 11/10 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending s after death. 1 🗌 Yes 2 No Accident Suicide Investigation the 6 Could not be within 24 hours after de To the Funeral Directo completed filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d Date signed (Month, Day, Year) UT oleted cause of death (Item 23a) (Type, Print) DEFENSE HWY ANNAPOLIS M.D. 2140

DHMH 17 Rev 7/2009

State Registrar JENEVIEUE

FOOT-TAYLOR

32. Registrar's Signature

H

			State of Maryland / Dep	partment of Health and lertificate of Death		iene leg. No.20	1 03083
			Decedent's Name (First, Middle, Last)		2. Date of Deat	th	3. Time of Death
	Physicia Medio		Harry Ohan		January	$17^{\text{pay}}, 201^{\text{Yea}}$	12:11A M
4	Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	1	4c. County of D	eath
-	4		Shady Grove Adventist Hospital	Rockville		Montgon	
	Funeral Director		5. Social Security Number 025-20-4505 6. Sex 1 1 1 M 2 F 7. Age (In yrs. last birthday, Yrs.	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, March 24	4, 1926 M	Birthplace (State or Foreigr Country) assachusetts
	d now	_	Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or L	ocation			10d. Inside City Limits
	arylan a-f sh fied a	cto					1 🗆 Yes 2 🗶 No
	th with the Maryland ms 23a or 28a-f show must be notified at	Funeral Director	Maryland   Montgomery   Silver S	10f. Zip Code		10g. Citizen of What	
	with t	eral	15301 Wallbrook Court	20906		United St	ates
	eath y	Ē		. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puert	pecify Yes or No-		merican Indian,
Maryland 21215-0036	nit. Page 1 and 2 should be filed within 72 hours after death with the Maryland artment of Health and Mental Hygiene. ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at	by	1 ☐ Never Married 2 ☑ Married  1 ☐ Never Married 2 ☑ Married  3 ☐ Widowed 4 ☐ Divorced  Armed Forces?  1 ☑ Yes 2 ☐ No 1950— If Yes, Give Year or Dates.	1 ☐ Yes 2 🔀 No Specify:	o Rican, etc.)	Black, W	
9-0	hour natu dical	Completed	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of wor	kina	16b. Kind of Busine	ess Industry
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7	d within dygiene.	Be C		1 Officer	## 1 44 data 1	Navy	
anc	uld be file Mental H narked of atic ever	To E	17. Father's Name (First, Middle, Last)  Mike Ohan	Zabel S	ne <i>(First, Middl</i> e, <i>N</i> Sciamsi	//aiden Surname)	
<u>_</u>	should be file and Mental is marked c		19a. Informant's Name/Relationship (Type, Print)	ling Address (Street and Number or Ru	ral Route Number.	City or Town, State,	Zip Code)
ž	d 2 shalth a alth a 27 is			l Wallbrook Court,		•	
ore,	of Hey of Hey if item rothe		20a. Method of Disposition  20b. Place of Disposition  1   Burial 2 □ Cremation 3 □ Removal from State  20b. Place of Disposition	position (Name of ematory or other place) May	Date 0	20c. Location - City	or Town, State
ij	Page ment tant: I		Dunal 2 - Olemation 3 - Hemovarion State	Vational Cemetery 201	li'' /	Arlington,	Virginia
Baltimore,	permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau		21. Signature of Funeral Service Licensee M01596	22. Name and Address of Facility Obert A. Pumphrey Fune 30 West Montgomery Aver	cal Home/Ro nue, Rockv	ckville , ille, Maryla	Inc. und, 20850
4.	9.		23a. Part 1. Enter the disease, or complications that caused the death. Do not er shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death
A	Physician Medical	8 11	Immediate Cause (Final disease or condition resulting in death)				Oriset and Death
4	Examiner		Due to (or as a consequence of):				
		Jer	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):				
	ted d ansit	dical Examiner	cause. Enter Underlying Cause (Disease or impry				
	be executed sician and burial-transit	Ë	that initiated events resulting in death) Last  C. Due to (or as a consequence of):				
09	e be o	lica	d				
876	tificat ng ph as th	Мес	IF FEMALE:				
Box 687	th cer tendii or use	ian/	23b. Was decedent pregnant   23c. If yes, outcome of pregnancy   1	Ectopic pregnancy		23d. Date of Month	delivery  Day Year
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Completed by Physician/Me	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 9 ☐ Unknown	Other (specify)		World	Day Teal
P.O.	at the	/ Ph	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tol	bacco use contribute	e to the cause of death?
S, F	ires tl sign	q p	End Stage Renal Diseas	e	1 🗆 Y	es 2 No 3 E	Probably 4 Unknown
ord	requer beer shou	lete	End Stage Renal Diseas Peripheral Vascular Dise	ase	24a. Was a		autopsy findings available
Division of Vital Records,	he law te has age 2	ошр	To the tast tast to		autops perfori 1  Yes		to completion of cause of 1? Yes 2 \Boxed No
E F	an: T	Be C	25. Was case referred to medical	26. Place of Death (Che		Z (BSLINO) I L	165 Z 🗆 140
Κ	nysici lis cer direc	To E	examiner? 1   Yes 2   YNo   Hospital: 1   Management   Hospital:   ER/Outpati	ent 3 DOA Other: 4 Nursing F	lome 5 Reside	ence 6  Other (Sp	pecify)
of	ng Ph fter th ineral	ite:	27. Manner of Death  1 Natural 5 □ Pending   28a. Date of injury (Month, Day, Year)   28b. Time injury	of 28c. Injury at work?	28d. Describe ho	w injury occurred	
ion	tendii leath. or: Ai the fu	ifica	2 Accident Investigation	M 1 Tes 2 No			
ivis	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completed filled in by the fu	Medical Certificate:	4 Homicide determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (St City or Town		Rural Route Number,
	pital ours a eral [	cal (	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death	occurred at the time, date and place a	and due to the caus	se(s) and manner as	stated
	e Hos 124 h e Fun leted	ledi	(Check 2 Medical Examiner: On the basis of examination and/or invention only one) 3 Certifying Nurse Practioner: To the best of my knowledge	estigation, in my opinion, death occurred	at the time, date an	d place, and due to the	he cause(s) and manner state
	To th withir To th	2	29b. Signature and title of certification	29c. License number		9d. Date signed (Mo	
	(-1		1 23 C	D0062435		Januar	y 17,2011
	15%		30. Name and address of person who completed cause of death (Item 23a) (Type, Sayed Elsayyad mb 10110 Mol		2 Ro	cleville	MD 20850
	Sta		31. Date filed (Month, Day, Year)  32. Registrar's Signature				
	Registra	ır ·	PEBUT 7011 Chana B. Darker				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decede t's Name (First, Middle, Last) Physician/ 9:10A M Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 33RD Str timore Birthplace (State or Foreign 8. Date of Birth If Unde **Funeral** Min. 1 M 2 X **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b, County 10c. City, Town or Location Funeral Director Yes 2 No timore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3 RD 040 E 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes No If Yes, Give Baltimore, Maryland 21215-0036 1 🗌 Yes 🔽 No laci( 3 Widowed 4 Divorced Year or Dates. 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) //Seconday)(0-12) College (1-4 or 5+) Be 18 Mother's Name (First, Middle, Maiden 17. Father's Name (First, Middle, Last) ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20c. Location - City or Town, State 20b. Place of Disposition (Name of Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 15 5 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as card shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death respiratory arrest. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury the attending physician and that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) 1 Yes 2 No Pregnant at time of death After this certificate has been signed by the a funeral director, page 2 should be detached a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2/ No 3 Probably 4 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Ø No 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical examiner? **Division of Vital** Be 26. Place of Death (Check only one) Other: 2 No ၉ 1 U Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Residence 6 - Other (Specify) 28a. Date of injury (Month, Day, Year) 28c, Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending Investigation 6 Could not be Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number by Law, MD DO 3

State Registrar 31. Date filed Month, Day, Year)

FER NY 2011

DHMH 17 Rev 7/2009

32. Registrar's Signature

3730 Falls

Road Baltimore

39. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 26. Physician/ JANUARY PEASLAND 2011 Year TERRY 10:36A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death FREDERICK FREDERICK FREDERICK MEMORIAL HOSPITAL If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs, last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Oct. 18,1946 1 X M 2 🗆 Months Days Hours Min New York **Director** 065-38-0555 64 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director MD Frederick 1 Yes 2 X No Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a o Funeral 9190 Oak Tree Ct. 21701 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces

1 X Yes 2 If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married þ 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 Divorced 4 Divorced Completed 1966-87 the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Federal government <u>Cartographer</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Theodore Peasland Ruth Donna Robinson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kerry A. Peasland - wife 9190 Oak Tree Ct., Frederick, MD 21701 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔲 Burial 2 😾 Cremation 3 🗆 Removal from State All County Cremation 1/29/2011 4 ☐ Donation 5 ☐ Other (Specify) Sykesville, MD 22. Name and Address of Facility 21. Signatur of Funeral Service Udensee Hartzler Funeral Home 11802 Liberty Rd., Libertytown, MD 21762 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ 6 disease or condition resulting in death) Medical Due to (or as a cor Examiner Sequentially list conditions. Examine if anv. leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) been signed by the attending physician and should be detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death 9 Unknown 9 Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No this certificate has ral director, page 2 1 🗌 Yes 2 🗆 No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? 2 No Hospital Other: 1 Yes ၉ 1 ÅInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, Manner of Death 28a. Date of injury hours after death. neral Director: After the filled in by the funeral 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural (Month, Day, Year, 5 Pending M 1 Yes 2 No Investigation <sup>\</sup>Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined To the Hospital or within 24 hours a To the Funeral D Medical 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basic of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State Registrar 29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Registrar's Signatur

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The failure Let only one cause on each line.  Throat Cancer  Throat Cancer  Use (Case (Final disease)  Sequentially its conditions.  Sequentially its conditions.  If any leading to immediate cause. Enter Underlying Clause  Cause. Enter Underlying Clause. Cause. Enter Underlying Clause. Cause. Enter Underlying Clause. Cause. Enter Underlying Clause. Cause. Enter Underlying Clause. Cause. Enter Underlying Clause. Cause.		L L		I AIA X	611		55 W. Ba	1timore	St; Bal	timore, 1	MD 21201
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29b. Signature and little of certifier  O.C.M.E.  January 10, 2011  30. Name and address of person who completed cause of death (Item 23a)  Ana Rubio MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223  State  31. Date filed (Month Day Year)  28c. Registrar's Signature	b. BC the dea	Phy		9 0000		esulting in the u	inderlying cause g	iven in Part I.	23e. Did to	obacco use contribu	ute to the cause of death?
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29b. Signature and little of certifier  O.C.M.E.  January 10, 2011  30. Name and address of person who completed cause of death (Item 23a)  Ana Rubio MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223  State  31. Date filed (Month Day Year)  28c. Registrar's Signature	Reco	E O									
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29b. Signature and little of certifier  O.C.M.E.  January 10, 2011  30. Name and address of person who completed cause of death (Item 23a)  Ana Rubio MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223  State  31. Date filed (Month Day Year)  28c. Registrar's Signature	On C on c ath. or: Aft	ţį	1 Natural 5 Pendi	(Month,	Day,Year)		1□ Y	es 2 No			
29b. Signature and little of certifier  O.C.M.E.  January 10, 2011  30. Name and address of person who completed cause of death (Item 23a)  Ana Rubio MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223  State  31. Date filed (Month Day Year)  28c. Registrar's Signature	Division Attust of Attust	rtifica	3 Suicide 6 Could	not be 2Be. Place	of Injury - At ho	orne, farm, stre	et, factory, office b	uilding, etc.			or Rural Route Number, City
29b. Signature and little of certifier  O.C.M.E.  January 10, 2011  30. Name and address of person who completed cause of death (Item 23a)  Ana Rubio MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223  State  31. Date filed (Month Day Year)  28c. Registrar's Signature	he Hospit in 24 hour he Funera		29a. Certifier 1 Certifying Phy	ysician: To the best							
30. Name and address of person who completed cause of death (Item 23a)  Ana Rubio MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223  State 31. Date filed (Month Day Year)  2. Registrar's Signature	To 1 To t	Med	2 🖳	and manner st							
Ana Rubio MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223  State 31. Date filed (Month Day Year)  Registrar's Signature			Questo.				O.C.N	M.E.		January 10,	2011
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niel M. Parish		State of Maryland / Department of Health and Mental H  - For State Certificate of Death  Registrar		eg. No. 2011	1 #3090
Physicia	n/	1. Decedent's Name (First, Middle,Last)	2. Date of Dea Month	Day Year	3. Time of Death 0700 hrs
edical Examir		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Deatl	January 3	4c. County of De	ath
		7123 Boxford Road Baltimore			
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hr  Months Days Hours Mir	_		Birthplace (State or reign TAYA/CA Country)
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death with the Maryland or items 23a or 28a-f sho must be notified at once.	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (S 14. Mever Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto		14. Race - An White, etc	nerican Indian, Black, :
		Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify:		Specify:	Black
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-003 1 within giene. ther th	Completed	17. Father's Name (First, Middle, Last)  18. Mother's Name  18. Mother	e (First, Middle,	Maiden Surname)	
nore, MD 21215-0036  ages I and 2 should be filed within 72 hours after death with the Maryland no Fleath and Mental Hygene.  t: If item 27 is marked other than "natural", or items 23s or 28s-fable other traumatic event, the Medical Examiner must be notified at once	BB	LEUI PAVISH JUANI		uright	
D 21 should and Me	유	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or 7123 Box for Co.)	Rural Route Nu	mber, Citý or Town, St	ate, Zip Code)  MD Z/Z//
를 들 등 달	4	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	Date	20c. Location - City	or Town, State
MOF6		1 Burial 2 Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify:	2/12/11	Akesu	1/EMB
Baltimore, permit. Pages la Department of He Important: If ite injury or other tr	ı	21. Signature of Funeral Service Licensee 22. Name and Address of Facility	KANY	122 - toma	Thous Nove
_ ====		23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac	or respiratory an	rest, shock, or heart	Approximate Interval
Physician Wedical		falture. List only one cause on each line.  Immediate Cause (Final disease a. Atherosclerotic Cardiovascular Disease			Between Onset and Death
Examiner		or condition resulting in death)  Due to (or as a consequence of):			
	<u>=</u>	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):			
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
executed an and al - transit	E	d.			
D, be exe sician a	edical	UNPENDED AMENDED		Tool Date of deli	
ox 68760, ant certificate be execut attending physician and or use as the burial - trai	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy  1 Live birth  2 Fetal death  3 Ectopic pregr	nancy	23d. Date of deli Month	Day Year
Box 6  death cer the attendi	Sicia	1 Yes 2 No 9 Unknown 9 Unknown		de la companya de la	
O. Be at the de d by the stached f		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			to the cause of death?
es the	g pe				Probably 4 Unknown
of Vital Records, ng Physician: The law requir ther this certificate has been s meral director, page 2 should I	Completed		24a. Was auto		autopsy findings available to completion of cause of 1?
tal Rec	Sol	25. Was case referred to medical 26. Place of Death (Chec		2 ✓ No 1	Yes 2 No
Vital hysician: this certi	Be	20 years and 10 committee to the desired to the des	sing Home 5	Residence 6 🗸 0	ther: Scene
ion of Vital literating Physician: eath.  or: After this certifithe funeral director.	n: To	27. Manner of Death  28a. Date of Injury (Month Day Year)  28b. Time of Injury 28c. Injury at Work?	28d. Describe	how injury occurred	
ivision or Attendi after death. Director:	catio	1 V Natural 5 Pending 2 Accident Investigation One of Investigation Accident Investigation Investiga	28f Location	(Street and Number o	r Rural Route Number, City
Division tal or Attendi rs after death.	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc.  (Specify)	or Town,		, marantoato manzon, on,
Division of Vital Internation of Vital Internation of Actions hin 24 hours after death. The Theorem The Funeral Director: After this certification, appletely filled in by the funeral director,		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and	nd due to the cau	use(s) and manner as	stated.
DIVI To the Hospital or within 24 hours afte To the Funeral Dir	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.  29b. Signature and title of certifier.	at the time, date	29d. Date signed	
	2	29b. Signature and title of certifier  29c. License number  O.C.M.E.		February 1, 2	
		30. Name and address of person who completed cause of death (Item 23a)	<u>-</u>		
		Melissa Brassell, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltim	ore, MD 212	223	
St		31. Date filed (Month, Day, Year) 32 Assistrar's Signature			

DHMH 17 Rev 1/2001 OCME 2006

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ORIGINAL

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	ysicia	ın/	<ol> <li>Decedent's Name (First, Middle,</li> </ol>					-	2. Date of D Month	Day	Year	3. Time of Death
Medical Ex	xamii		Rose Elizabeth  4a. Facility Name (if not institution,		1	I 4h Ci	ty, Town, or Lo	cation of Dea	January		111 c. County of Dea	
		н	3503 Dahlia Lane	, give street and number	,	The second second	ddle River				Baltimore Co	
Fun Dire				6. Sex 7. A	ge (In yrs. last 78		Inder 1 Year onths Days	Hours Mi		•	1Fore	Birthplace (State or eign countryMaryland
		þ	Usual Residence of Decedent		Tre on a							10d. Inside City Limit
	# # .		MD Balt:	imore		wn or Location	r					1 Yes 2 N
ryland	28a-f show	턍	10e. Street and Number	Imo I C	11140		Zip Code			10g. Cit	izen of What Co	ountry?
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.	23a or 28 notified a	Dire	3503 Dahlia La		Francis N.C.		21220	onio Osigina / S	Specify Yes or	US		erican Indian, Black,
death wi	or items must be	Funeral	11. Marital Status 1 Never Married 2 Mar	1 Yes 2		If Yes, sp	pecify Cuban, N	/lexican, Puerl	to Rican, etc.)	140-	White, etc.	
rs after	niner	2	Widowed 4 Divor  15. Decedent's Education (Speci	rced If Yes, Give Year or Dates: fy only highest grade co	moleted) 16	1 Yes	2 X No		work done	16b.	Specify: Kind of Busines	white s/Industry
2 hour	Exa	Completed	Elementary/Secondary (0-12)	College (1-4 or		during most of						•
036 ithin 7	r than fedica	ğ	12	0		laborer					warehou	se
<b>5-0</b> filed w Hygie	d other		17. Father's Name (First, Middle, L						ne (First, Middle	e, Maider	Surname)	
2121 lid be i	event	To Be	William Ballar  19a Informant's Name/Relationshi			19b. Mailing Add		Ruby To		lumber, (	City or Town, Sta	ate, Zip Code)
AD 2 shou h and I	27 is r		Annette Zellho		ì	_	•				r, MD 2	
l and Healt	fitem er trau	Ī	20a. Method of Disposition  1 Burial 2 Cremation		20b. Pla	ce of Disposition (	Name of ceme		Date		Location - City	
MOI Pages	r oth		4 X Donation 5 Other Spe		, ale							
Salti ermit.	nport	1	21. Signature of Funeral Secure L	icensee	rector_						y Board	
		4	23a. Part I. Enter the disease, or c	//xxcr	d the death. Do						more, M	Approximate Interva
Physic /N	fical		failure. List only one cause o	on each line. a. <u>Atherosc</u>								Between Onset and Death
Ēxam	iner		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a cons	sequence of):	Cardiov	asculu	I DIBO		71		
		اءِ	Sequentially list conditions, if any leading to immediate	b. Due to for as a con-	sequence off:							
		Examiner	cause. Enter Underlying Cause (Disease or injury that initiated	С								
P	ısit	Exar	events resulting in death) Last	Due to (or as a con:	sequence of):							
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60, ate be	attending physician and for use as the burial - tra	an/Medical	IF FEMALE:	23c. If yes, outco		_				-	3d. Date of deliv	ery
<b>687</b> ertific	ding p	ian/	23b. Was decedent pregnant in the past 12 months?		at time of death	2 Fetal de		Ectopic preg	nancy	-	Month	Day Year
30X death o	e atten for us	Physicia	1 Yes 2 No 9 Unkr	· L	it time of death	5 Other (	Specify)					
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be execut within 24 hours after death.	has been signed by the 2 should be detached f	à	Part II. Other significant condition	contributing to dea	th but not resu	Iting in the underl	ying cause giv	en in Part I.				to the cause of death? robably 4 Unknown
ds,	ould b	Completed							24a. W	as an topsy		autopsy findings available completion of cause of
OCO.	te has ge 2 sl	Ē				-				rformed?	death	?
2 =	certificate rector, page		25. Was case referred to medical					f Death (Chec				lus-
Vita	di j	To Be	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpat		VOutpatient 3					ence 6 🗹 Ott	ner: Scene
on of ending P	In Africa	Certification:	27. Manner of Death  1 Natural 5 Pendin		Year)	3b. Time of Injury 1 1115 h	28c. Injury	at Work? s 2 🗶 No	28d. Describes subjection	ect f		very cold
Visi or Att	Direct in by	tifica	3 Suicide 6 Could	not be 28e. Place of	Injury - At home	e, farm, street, fac		lding, etc.	28f. Locatio	n (Street	and Number or	Rural Route Number, Cit
Divis Hospital or 4	filled ,	9	4 Homicide determined	(-5)/	esidenc							hlia Lane
the Ho	To the Funeral Director: completely filled in by the	edical	(Check only Certifying Fit)	ysician: To the best of r	amination and/							
To the	To	Med	29b. Signature and title of certifier	and manner stated			29c. License					Month, Day, Year)
			Chambrite D	ne Male			O.C.M	.E.		Jai	nuary 15, 20	11
			30 Name and address of person v	who completed cause of	death (Item 23	ia)						

State Registrar

Margarita Korell MD. Ass 31. Date filed (Month, Day, Year) FEB 0 7 2011

2. Registrar's Signature

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death RYAN Physician/ EIAINE 4:01 AM 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BAILEY ROAD FOREST HARFORE 2635 HILL 9. Birthplace (State or Foreign Country) MD If Under 1 Year If Under 24 Hrs. 8. Date of Birth 6. Sex 7. Age (In yrs. last birthday) Social Security Number 212-36-5647 Funeral Months 11/14/1938 72 **Director** Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Me "ical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov amy injury or other traumatic event, the Me Itaal Examiner must be notified at once. 10b. Count 10d. Inside City Limits 10a. State 10c. City, Town or Location Director Forest Hill Harford 1 🗌 Yes 2 🏝 No 10f. Zip Code 21050 10e. Street and Number 10g. Citizen of What Country? Funeral 2635 Bailey Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2 ☐ You Black, White, etc. Specify: White 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Service Bar Maid Be Father's Name (Eirst, Middle, Last) Roy James Howell 18. Mether's Name (First Middle, Maiden Swinne) r ဂ 19a. Informant's Name/Relationship (Type, Print)
Clarence Ryan / Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Zip Code)
2635 Bailey Road, Forest Hill, MD 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Final Journey crem. 1 Burial 2X Cremation 3 Removal from State 2/6/2011 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Cremation Services
PO box 1413, Baltimore, MD21203 21. Signature of Funeral Service Licensee Dorota Marshall 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final CANCER Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate Due to (or as a consequence of): Cause Enter Underlying Cause (Disease or linjury Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☒ No 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ for Month Year Day Pregnant at time of death signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Obstructo 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? certificate has director, page 2 performed? Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA After this within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral of 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28h Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending work?
1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 XCertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 ☐ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier a wals 1 39. Name and address of person who completed cause of death (Item 23a) (Type, Print)
LINDA A. WAUSH MD 3718 Norms will Rd, SteC, threethsuille

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Feb. 2011 Physician/ 6:25am M Wilbur E. Shipley Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Lutheran Village Health Care Westminster Carroll 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 x M 2 □ F Hours Min. Mar 21, Year 922 Country) 216-14-6755 MD 88 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City. Town or Location 10d. Inside City Limits Director MD Carroll Finksburg 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4457 Louisville Road 21048 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married X Yes 2 ☐ No Yes, Give Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify: White 3X□ Widowed 4 □ Divorced WWII Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Construction <u>Carpenter</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Theodore Shipley Ethel Richardson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Arthur Brauning (Brother-in-law) 4457 Louisville Road, Finksburg, MD 21048 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 KBurial 2 Cremation 3 Removal from State Providence Cemetery 2/7/2011 Gamber, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PA 21. Signature of Funeral Service Licensee PO Box 195 Sykesville, MD 21784 1100764 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) -Physician/ Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of) sician and burial-transit Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Dav Pregnant at time of death Other (specify) 1 Yes 2 No been signed by the should be detached 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 N Hospital or Attending Physician: The 1 Yes of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one, examiner?

1 Yes Other: 2 No ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🔀 Natural 5 Pending Division 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State, Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d Date signed (Month, Day Year) 20/ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 01/21 / 11 Physician/ 22:30 M Helen K. Slash Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince Georges Washington Medical Center Fort Washington Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday, **Funeral** 1 🗆 M 2 🛣 F Virginia Days Hours 08730749 **Director** 232-82-5276 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10c. City, Town or Location
Fort Washington 10d. Inside City Limits within 72 hours after death with the Maryland Director MD Prince Georges 1 Yes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 20744 USA 1905 Taylor Ave Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian Armed Force Black, White, etc. þ 1 X Never Married 2 Married 1 Yes 2 X No Maryland 21215-0036 1 Yes 2 No Specify Specify: Black 3 Widowed 4 Divorced Completed Year or Dates raried other than "natur rati: event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Universal Hair permit. Page 1 and 2 should te filed within Department of Health and Mental Hygiene. Important: If item 27 is a rected other than any injury or other traur ati: event, the N Cosmetologist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Catherine Swain Clifford Slash 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 1905 Taylor Ave Ft. Washington MD 20744 Geraldine Slash /sister Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 1/29/11 Beltsville, MD Chesapeake Crematory 21. Signatura of Funeral Service Licensee 22. Name and Address of Facility 420 H StreetNE BK Henry Funeral Chapel Wash DC 23a. Part 1. Outer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Pnysician disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Exami the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit and that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No for Year Month Day Pregnant at time of death 5 Other (specify) should be detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed Yes 2 certificate has 1 Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 1 🗌 Yes 2 No Other: ပ 1 Inpatient 2 FER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) this or Alte.

s after death.

al Director; After the two the funer. 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred (Month, Day, Year) injury 1 Natural 5 Pending 1 Yes 2 No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide 24 hours after a Funeral Direc determined Medical ✓ Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier The dical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. Within 2 29b. Signature and title of certific 29d. Date signed (Month, 29c. License numbe DO053117 24 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3 Patrick W. Daly, 11711 Livingston RD Fort Washington MD 20744

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 4.20 A M evucary Medical Facility: Name (if not institution, give street and number) Town, or Location of Death 4c. County of Death Examiner 4b. City, KaltiMore If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Age (In yrs. last birthday) **Funeral** Months 1 🗆 M 2 💢 F lamaieu Director ral", or items 23a or 28a-f shov Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Raltimore 1 X Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 21239 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ⚠ No If Yes Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Completed by 1 X Never Married 2 - Married 1 Yes 2 If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) 1eac Be 17. Father's Name (First, Middle, Last) 18 Mother's Name (First Middle, Maiden Surname ပ္ Inorpe SIMEON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route dirother 21234 Hurnwood Method of Disposition

1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, Moodlawr 4 ☐ Donation 5 ☐ Other (Specify) Signatur - Fune I Servic Licensee Part 1. Enter the disease, or complications that caused the death. Do not entertibe shock, or heart failure. List only one cause on each line. mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death h, sician/ disease or condition Medical resulting in death) consequence of) Examiner Gequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transi been signed by the attending physician and should be detached for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No Day Pregnant at time of death 1 ☐ Yes ∠ ≠ g ☐ Unknown a I Inknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown 24b. Were autopsy findings available 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 s prior to completion of cause of death? performed? Yes 2 No 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 No Hospital Other Certificate: To 1 Inpatient 2 ER/Outpatient Nursing Home 5 - Residence 6 - Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Tes 2 🗌 No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

5 60 ( Lo 31. Date filed (Month, Day, Year,

FEB

32. Registrar's Signature

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	•	for State Registrar	State of	i iviai yiai i	•	tificate of		ivieritai i iy	Reg. No.		03095
Physicia	n/	1. Decedent's Name (First, Middle						2. Date of De Month Feb	eath	1 Year	3. Time of Death
Medic	al	Bernard Swerb  4a. Facility Name (if not institution,		her)		4b City Town o	or Location of Deatl		4c, Count		7:30 P M
Examin	er	Mandrin Hospice  5. Social Security Number	House	7. Age (In yrs. Ia	ant hinthelass	Harwoo		8. Date of Bir	Ann	e Arı	unde1
Funeral Director		216-12-3702 Usual Residence of Decedent	1 M 2 D F	90	Yrs.	Months Days	Hours Min.	6/12/1		Coui	
aryland a-f show fied at	ector	10a. State 10b. County	Arunde1		y, Town or Loc						10d. Inside City Limits 1   Yes 2 □ No
ith the Mi 3a or 28 it be noti	Funeral Director	10e. Street and Number  133 Archwood Av		All	шаротт	10f. Zip Code 2140	1		10g. Citizen of	What Cou USA	intry?
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status  1 Never Married 2 XMarr 3 Widowed 4 Divorced	12. Was Deced Armed For 1X Yes If Yes, Give	2 🗆 No <b>WWI</b>	T If	as Decedent of H	Hispanic Origin? (Span, Mexican, Puert		14. Rad Bla		_
72 hours n "natura Nedical E	Completed	15. Deceder (Specify o <i>nly high</i> e	Year or Dat nt's Education st grade completed)		(Give k.	ent's Usual Occup ind of work done ONOT use retired	during most of wor	king	16b. Kind of E	Business Ir	ndustry
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ild be file Mental F larked of atic ever	To B	17. Father's Name (First, Middle, L Jacob Swerbilow	,		,		18. Mother's Nar		, Maiden Surnam	ie)	
d 2 shou alth and 27 is m er traum		19a. Informant's Name/Relationsh Elsie Swerbilow					and Number or Ru Ave, An				Code)
Page 1 an nent of He int: If iten iry or oth		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		State		sition (Name of atory or other pla srael Ce		Date /2011	20c. Location Annapol	•	
permit. Departn Importa any inju		21. Signature of Funeral Service L	icensee				ess of Facility Ha y Ave, A				
Ř		23a. Part 1. Enter the disease, or shock, or heart failure. List of	nly one cause on eac	ch line.	h. Do not ente	the mode of dyir	ng, such as cardiac	or respiratory ar			Approximate Interval Between Onset and Death
Physician/		Immediate Cause (Final disease or condition resulting in death)	Due to (c	or as a consequ	uence of):	d Lei	ekemea			$\dashv$	
p #	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (c	or as a consequ	uence of):	D- A	2DIAL	ECC			
be executed sician and burial-transit		Cause (Disease or iinjury that initiated events resulting in death) Last	Due to (c	or as a consequ	uence of):		ISCASE		7.601		
ertificate ding phys se as the	/Medi	IF FEMALE: 23b, Was decedent pregnant	23c. If yes, outc	ome of pregna	ncy	`			23d D	ate of deliv	ven
To the Hospital or Attending Physician: The law requires that the death certificate be ex within 24 hours after death.  To the Funeral Director After this certificate has been signed by the attending physician completed filled in by the funeral director, page 2 should be detached for use as the burial promotes and the surface of the s	Completed by Physician/Medical	in the past 12 months?  1 Yes 2 No 9 Unknown		ant at time of o		Ectopic pregnan Other (specify) _	cy			onth	Day Year
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ending I eath. or: After the funer	Certificate:	1 Natural 5 Pendin 2 Accident Investig 3 Suicide 6 Could	g (Monti	h, Day, Year)	injury	28c. Inju wor M 1		28d. Describe I	how injury occur	red	
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he Hospi in 24 hou he Funer ipleted fill	Medical	(Check 2 Medical E	Physician: To the be xaminer: On the basi Nurse Practioner: T	s of examination	n and/or investi	gation, in my opini	ion, death occurred	at the time, date	and place, and du	ue to the ca	ause(s) and manner stated
To the With Conf.		29b. Signature and title of certifier	-MD.			29c. Licens	iqq7		29d. Date signe		
2+11		30. Name and address of person of ANDRON GORDO	who completed cause	e of death (Item	1 23a) (Type, Pr	int)		MAPOL			21401
Stat Registra		ANDRON SORDO 31. Date filed (Month, Day, Year) FEB 0 7 2011	Geneva 32. Re	gistrar's Signat	ture	7			, _		

DHMH 17 Rev 7/2009

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		Registrar  1. Decedent's Name	e (First, Middle	, Last)					ale of L	Jeann	2. Date of	Reg.	No.		3. Time of Death
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Funeral		5. Social Security No	umber	6. Sex 1 X M 2	7. Ag	je (In yrs. i		Mont	der 1 Year	If Under 24 Hr Hours Mir			ar) 9.	Birthp Count	place (State or Foreign
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permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once.		1 🔀 Burial 2	☐ Cremation		al from State	, (	cemetery,	crematory	r other plac	1 2/	7/2011			•	
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thin 2 thin 2 the I	Me	only one) 3 29b. Signature and		Nurse Practi	oner: To the	best of m	y knowle		ccurred at the	e time, date and p	olace, and due to	_	use(s) and manne Date signed (M		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February 2, 2011 each 12:55 P M Sullivan Palmer Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Montgomery Rebecca House Potomac 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) Funeral 1 ፟ M 2 ☐ F Davs Hours Min October Mary land 1925**,**1925 Director 220-16-6093 Usual Residence of Decedent ems 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City. Town or Location 10d Inside City Limits filed within 72 hours after death with the Maryland Director 1 Yes 2 No Maryland Potomac Montgomery 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral United States 20854 12265 St. James Road 12. Was Decedent Ever in U.S. Armed Forces?

1 🖾 Yes 2 🗌 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Examiner Black, White, etc. "natural", or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates. WW II Completed Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Il Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) the U.S. Government Patent Classifier Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental h 0 pe t Blanche DeVol Kern Randolph Sullivan Page 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sl Department of Health a Important: If item 27 is any injury or other tra Maryland 20854 12265 St. James Road Potomac, Celia H. Sullivan / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) February 20a. Method of Disposition 20c. Location - City or Town, State 1 🗆 Burial 2 💢 Cremation 3 🗀 Removal from State Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2011 Crematorium. Inc 22. Name and Address of Facility
Robert A. Pumphrey Funeral Home Bethesda-Chevy Chase, Inc.
Rethesda, Maryland 20814 Signature of Funeral Service Licensee the J. Shr M01360 23a. Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line terval Between Onset and Death Years Immediate Cause (Final Alzheimer's dementia Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of): the burial attending physiciar Physician/Medical P.O. Box 68760 as IF FEMALE: JSe 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) \_\_\_\_ Live Birth 2 Fetal death in the past 12 months?

1 Yes 2 No for Month Day Year Pregnant at time of death 9 Unknown ģ Part I<mark>I. Other significant condition</mark>s contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown Completed page 2 should has been 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed? Yes 2 K No certificate 1 Yes 2 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 🗷 Nursing Home 5 🗌 Residence 6 🗌 Other (Specify) Hospital: 2 🔀 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA he Funeral Director; After the related filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Tyes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital 24 hours Medical 🖾 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the I within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0061382 2/3/2011

Registrar
DHMH 17 Rev 7/2009

14816 Physicians Lane #152 Rockville, Maryland 20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Shama Mittal, M.D.

2011

31. Date filed (Month, Day, Year)

FEB 07

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Month Year 3:50 PM January 201 Medical 28 City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) County of Death Examiner attimore HOS NA Security Number 42 8400 If Under 1 Year If Under 24 Hrs. 6. Sex last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 D F 42 Director Usual Residence of Decedent show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 23a or 28a-f Yes 2 No Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 21229 Jamestown 454 permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items: any injury or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes : Baltimore, Maryland 21215-0036 1 Yes 2 No Black Specify: 3 Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NQT use retired) (Specify only highest grade completed) /Seconday (0-12) College (1-4 or 5+) sabled Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ unk 19a. Informant's Name/Relationship (Type, Print 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brown dale Windsor Mill 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 22 Name and Address of Facility BAY P. MOCCH, F 2 TO FREAM HON . Signature of Funeral Service Licens BAUD 23a. Pay 1 Eplertife disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death Physician/ Brady Cardia
Due to (or as a confequence of) disease or condition resulting in death) leading Medical Examiner ardiac Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) s been signed by the attending physician and should be detached for use as the burial-transi the Hospital or Attending Physician; The law requires that the death certificate be executed Orm any Due to (or as a consequence of): resulting in death) Last Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death Physician/ 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) Pregnant at time of death 9 Unknown 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Vunknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of cate has b page 2 sl autopsv perform certificate | Yes 2 No 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 💢 No 1 Nation 2 ER/Outpatient 3 DOA After this of မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural injury work? 5 Pending death. within 24 hours after death.

To the Funeral Director A completed filled in by the fi Accident
Suicide Investigation 6 Could not be . Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier AT2438946 28. 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Glister MD Union Hemoral Hospital East University Phury

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

FEB 07

32. Registrar's Signature

	_	For State Registrar		Se Type or P ER ANA BD State of			rtificat					Reg. No	7 11		USIU
ysiciaı	n/	1. Decedent's Name (I	First, Middle	, Last)							2. Date of De		ly oo	Year	3. Time of Death
ledic	al .	Eugene Sa		ni give street and numbe	rl		4b City	Town or	Location	of Death	January		20 . . County		3:24 P
mine	er	Suburban			'/			thes		TOT Death			Mont		
		5. Social Security Num <b>285–34–50</b>	nber 68			ast birthday)	If Unde Months	r 1 Year Days	If Unde Hours	r 24 Hrs. Min.	8. Date of Bird (Month, Da March	th y, Year)	100/	9. Birth Cour	place (State or Fore htry) eece
	ŀ	Usual Residence of De			86	Yrs.					March .	15,	1924	Gr	eece
	tor	10a. State 1	0b. County			y, Town or L									10d. Inside City Lim
I	Sirec	MD 10e. Street and Number		gomery	В	etheso		0 1							1  Yes 2 1
	lal	6218 Lon		Dr.				0 Code 0 8 1 2					tizen of W	vnat Cou	ntry?
	- 1	11. Marital Status  1  Never Married  3  Widowed 4	d 2 ☑ Marr	12. Was Decede Armed Force	s? D No	S. 13.	Was Decedif Yes, spen				ecify Yes or No- Rican, etc.)			k, White,	
	ete 			it's Education st grade completed)	•	16a. Dece	edent's Usu	al Occupa	ation	st of work	ina	16b. k	(ind of Bu	siness In	dustry
	e Completed by	Elementary/Second	day (0-12)	College (1-4 o	or 5+)	life. L	kind of wo DO NOT us gineer	e retired)	uning mo	St Of WORK	<u></u>	S	truc	tura	1
	To B	17. Father's Name <i>(Fir</i> Paul San								udy .	e (First, Middle, Bunn	<i>Maid</i> en	Surname	)	
		19a. Informant's Name Hildega		ip <i>(Type, Print)</i> ntorini – v	vife						al Route Numbe thesda,				
		20a. Method of Dispos 1 ☐ Burial 2 ☐ 4 🛂 Donation 5	Cremation	3 ☐ Removal from Sta		Place of Disp cernetery, cre	matory or o	ther plac			Date				own, State
		21. Signatur Funer	ral Service	censee Wade	recto	2					st; Bal				21201
ĺ		23a. Part 1. Enter the shock, or heart for	disease, on ailure. List o	complications that cau nly one cause on each	sed the deat line.	h. Do not en	ter the mod	e of dying	g, such as	s cardiac	or respiratory an	rest,			Approximate Interval Between
	i	Immediate Cause (Fin disease or condition resulting in death)	nal	a. Due to (or	as a consequence	,	t 1	ntec	tio.	<i>J</i> .				-	Onset and Death
١	ner	Sequentially list cond if any, leading to immo cause. Enter Underlyi	litions, ediate	b. Due to (or	s a consequ									$\dashv$	
	Examiner	Cause (Disease or iinj that initiated events resulting in death) Las	jury	C. Due to /or	as a consequ	ience off:								-	
ı	- 1	resulting in death) Las	SI.	d	as a consequ	defice off.									
		IF FEMALE: 23b. Was decedent proint the past 12 mo 1  Yes 2 1	onths?	23c. If yes, outcor 1  Live Birl 4  Pregnar 9  Unknow	h 2 🗆 Feta It at time of a	aldeath 3	☐ Ectopic ☐ Other (s)		у				23d. Dat Mor		rery Day Year
	by P	-		ns contributing to deat	h but not res	ulting in the	underlying	cause giv	en in Par	t I.					he cause of death?
	ted	Demention	l-								1 🗆	Yes 2	No	3 🗌 Pro	bably 4 🗆 Unkno
	Completed										24a. Was autop	OSV	p	Vere auto prior to co leath?	psy findings availal empletion of cause
	Š	25. Was case referred	to medical					00 PH	<del></del>		perfo	2 1 N	0 1		2 🗆 No
	To Be	examiner?  1 \( \sum \) Yes 2		Hospital:	atient 2 🗆	ER/Outpatie	ent 3 $\square$ D	Othe	)r'	,	k only one)	dence f	5 ☐ Othe	r (Specifi	v)
	Certificate:	27. Manner of Death 1 ☐ Natural 2 ☐ Accident	5 Pendin	28a. Date of i (Month,		28b. Time of injury		28c. Injury work	at		28d. Describe h				
		3 ☐ Suicide 4 ☐ Homicide	6  Could determ	nod 28e. Place of	Injury - At ho etc. (Specify	ome, farm, st	reet, factor	y, office			28f. Location (S City or Tox			r or Rura	I Route Number,
	Medical	(Check 2	Medical E	Physician: To the best xaminer: On the basis of Nurse Practioner: To	of examination	n and/or inve	stigation, in	my opinio	n, death o	occurred a	t the time, date a	and place	e, and due	to the ca	use(s) and manner s
1		29b. Signature and	e of certifier					c. License	number			29d. De	1.	(Month,	Day, Year)
	Į.												~ 1 1 1		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Velma Samuelson Jean Physician/ Month 2011 Februari :02 PM Medical 4a. Facility Name (if not institution, give street and number Examiner 4b. City, Town, or Location of Death County of Death rowson Joseph Medical more enter . Social Security Number 213-22-0054 If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) 1 □ M 2 1 F 83 Months Davs Yrs Director Oct. MD Usual Residence of Decedent 28a-f shov 10a. State 10b. County with the Maryland ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Cockeysville 1 Yes X No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10535 York Road, Apt. I 21030 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 72 hours after White If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify. 3 Widowed WDivorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene. is marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) filed within Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Page 1 and 2 should be ment of Health and Menta unkn. unkn. injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is Son 1760 Potomac Greens Dr., Alexandria, Christopher Gentile / Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Final Journey crem. 4 ☐ Donation 5 ☐ Other (Specify) 2/6/2011 Woodbine, MD 21. Signature of Funeral Service Ligensee Dorota Marshall Maryland Cremation Services PO box 1413, Baltimore, MD Marsho 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ hronic disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner neumonia Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) Fibril To the Hospital or Attending Physician: The law requires that the death certificate be executed lattor attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery Month Dav Year Pregnant at time of death 4 ☐ Pregnant 9 ☐ Unknown ounce runeral purector. After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 
Yes 2 24a Was an oothyroidism Yes 2 25. Was dase referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No ၉ 1 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 24 hours after death. Funeral Director: After this 27. Manner of Death 1 Natural . Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 5 Pending Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Pactioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 02-04-11 D52740 30. Name and address person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

7505 Osler Drive

Towson

Hirpara

31. Date file (Month; Day, Year)

M.D

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 23a pt. II. 25 per me 2912 2-24-11 vt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Physician/ 10:18 A M Secola 2011 Helen JANUARY Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner Baltimore Hopkins Bayview Medical Cente 9. Birthplace (State or Foreign Country) VA If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 218 – 48 – 1447 Funeral Days 1 □ M 2 🖾 F Hours Min. 0 1927 1948 **Director** Usual Residence of Decedent 10d. Inside City Limits or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c, City, Town or Location 10a. State Director Dundalk Baltimore MD 1 Yes 2 No 10f. Zip Code 21222 10g. Citizen of What Country? 10e. Street and Number 2020 Codd Avenue Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 14 Bace - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes If Yes, Give Completed by Specify: White Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) 1 2 Own Home Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) Helen Torn 17. Father's Name (First, Middle, Last) 2 George Phillips 19a. Informant's Name/Relationship (Type, Print)
Michael Etzel / Friend 19b. Mailing Address (Street and Number or Rural Boute Number, City or Town, State Zin Code, 2020 Codd Avenue, Dundalk, MD 21222 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Woodbine, MD 2/4/2011 Final Journey Crem. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Dorota, Marshall 22. Name and Address of Facility
Maryland Cremation Services
PO Box 1413, Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death Immediate Cause (Final disease or condition herniation Physician/ Brain Medical resulting in death) Due to (or as a consequence of Examiner 48 hours Intracerebra Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner THE TOTAL PROPERTY OF CERTIFICATION APPROVED BY MEDICAL EXAMINER the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last and the burial-tran Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Hypertension Completed 24b. Were autopsy findings available 24a. Was an autopsy performed Yes 2 No prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) 25. Was case referred to medica Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Yes 1 Inpatient 2 ER/Outpatient 3 DOA ပု funeral ( 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completed filled in by the fu Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 24 3 🗌 only one 29d. Date signed (Month, Day, Year) 29b. Signature and title of 29c, License number 2011 RES-000 JANUAVY person who completed cause of death (Item 23a) (Type, Print) 30. Name and address MD 21224 BALTIMOVE EASTERN M.D 4940 Avenue Bradley 31. Date filed (Montif, Day, Year) State Registrar

DHMH 17 Rev 7/2009

			For State	State of M	laryland / Depa				2111	1 03103
		Tastate Registrar  Certificate of Death  1. Decedent's Name (First, Middle, Last)  2. Date of Death					3. Time of Death			
	2. Bate of Boats			Day Ye						
	Examir		4a. Facility Name (if not institution, gir	ve street and number)		4b. City, Town, or	Location of Deat		4c. County of D	Death
man of			Doctors Commun			Lanham			Prince	e Georges
45	Funeral Director			Sex 7. Ag 1 □ M 2 🖾 F	ge (In yrs. last birthday) 99 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		1911 <sup>9.</sup>	Birthplace (State or Foreign Country)
	d wor	]_	Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	nation				10d. Inside City Limits
	arylar a-f st fied a	Director	,	Georges	Lanham	cation				1  Yes 2 No
	or 28	ă	10e. Street and Number	8-1		10f. Zip Code		1	l 0g. Citizen of What	
	s 23a ust b	Funeral	8200 Good Luck	: Rd		20706			USA	
9003	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	þ	11. Marital Status unk 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1  Yes 2 If Yes, Give Year or Dates.	No	Vas Decedent of His f Yes, specify Cuban	, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - A Black, W Specify:	American Indian, Vhite_etc. black
Maryland 21215-0036	ithin 72 ho ene. r than "nat the Medica	Completed	15. Decedent's (Specify only highest g		(Give I	lent's Usual Occupa kind of work done du O NOT use retired)	tion <b>ünk</b> Inin <i>g m</i> ost of woi	rking	16b. Kind of Busine	ess Industry unk —
land 2	be filed w fental Hygi rked othe	To Be	17. Father's Name (First, Middle, Last,				18. Mother's Nai	me (First, Middle, N	faiden Surname)	unk
, Mary	d 2 should alth and M 1 27 is mai	2 55	19a. Informant's Name/Relationship (Margarie Jacks	Type, Print) On - niece	19b. Mailin 590	g Address (Street ar )4 Cherryw	nd Number or Ru 700d Ter	ral Route Number, race; Gre	City or Town, State eenbelt,	, Zip Code) MD 20770
Baltimore,	permit. Page 1 ar Department of He Important: If iter any injury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ③ Other (Spec	Removal from State		sition (Name of natory or other place	)	Date	20c. Location - City	or Town, State
Balt	permit Depart Import any inj		21. Signatur of Funeral Service Licer Ronald	WILL			altimore	St; Balı	timore, M	
_	Trysician/		23a. Pan 1. Enter the disease, or cor shock or heart failure. List only Immediate Cause (Final disease or condition	nplications that caused one cause are ach line	d the death. Do not ente	r the mode of dying,	such as cardiac	or respiratory arre	st,	Approximate Interval Between Onset and Death
	Medical  Examiner  bhysician and the privaletransit the privaletransit	J.	resulting in death)  Sequentially list conditions,	b. PVE	a consequence of):	via				
		dical Examiner	ii any, leading to immediate oue to (or as a consequence of): cause. Enter Underlying Cause (Disease or iinjury that initiated events  c.							
09			resulting in death) Last	Due to (or as	a consequence of):					
387	ertifica ding p	/Me	IF FEMALE:	One House entreme	-6					
). Box 687	/sician s certifii director,	hysicia	23b. Was decedent pregnant in the past 12 menths? 1 ☐ Yes 2 ★ No 9 ☐ Unknown	23c. If yes, outcome 1  Live Birth 4  Pregnant a 9  Unknown	2 Fetal death 3 E	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
ds, P.O.			Part II. Other significant conditions		ut not resulting in the ur	nderlying cause give	n in Part I.			e to the cause of death?  Probably 4 🗆 Unknown
Division of Vital Records,								24a. Was an autops perform	y prior death	
ta		Be	25. Was case referred to medical examiler?	Hospital:			e of Death (Chec	ck only one)	,	7
<b>)</b>		2	Yes 2 ☐ No 27. Manner of Death	1 Inpatie	ent 2 ER/Outpatient		4 ☐ Nursing H		nce 6 Other (Sp	pecify)
0 0	ding th. After fune	cate	1 Natural 5 Pending 2 Accident Investigation	(Month, Day		28c. Injury a work? M 1 1 7	es 2 □ No	28d. Describe hov	w injury occurred	
ivisio	To the Hospital or Attending Phy within 24 hours after death.  To the Funeral Director: After this completed filled in by the funeral of	Certificate:	3 Suicide 6 Could not I	oe 280 Place of Inju	ıry - At home, farm, stre c. (Specify)		2 2 110	28f. Location (Str. City or Town,		Rural Route Number,
Ω		edical	(Check 2 L Medical Exam	iner: On the basis of ex	my knowledge, death o	gation, in my opinion,	death occurred a	at the time, date and	place, and due to the	he cause(s) and manner stated.
	To the within To the Compl	2	only one) Certifying Nur 29b. Signature and the certifier	Se Fractioner: 10 the	best of my knowledge, de	29c. License r				ras stated.  With, Day, Year)
			30. Name and address of person who	completed cause of de	eath (Iten/23a) (Typ/, Pr	int) NAT	81126	an lord	ROAX LA	NHAW, MB FINGS
	Stat Registra	_	FEB 0 7 201	2. Registra	r's Signature		011 () 41	NO NOCK	19 ~7	100/00 30/06
	- I Colour	•	1 LD 0 ( 20	- Julian	To Salan					

Douglas Craig Tede	lerick State of Maryland / Department of Health and Mental Hygiene  1- For State Registrar  Certificate of Death Reg. No.	3104
Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last)  Douglas Craig Tederick  2. Date of Death Month Day Year January 27, 2011  3. Time of 1810	
	4a. Facility Name (if not institution, give street and number)  Meritus Medical Center  4b. City, Town, or Location of Death  Hagerstown  4c. County of Death  Washington	
Funeral Director	5. Social Security Number 232-90-3348 6. Sex 1 7. Age (In yrs. last birthday) 54 Yrs. 1   X   M 2   F   F   F   F   F   F   F   F   F	ate or 7
ond show any ice.	MD Washington Hagerstown	e City Limits
the Maryland is or 28a-f show stiffed at once.	10e. Street and Number 655 South Potomac St., #3 10f. Zip Code 21740 10g. Citizen of What Country? USA	
er death with renus 23 renust be no	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, White, etc. 15. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 16. White, etc. 17. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 18. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 19. White, etc.	Black,
5-0036 ed within 72 hours afti tygiene. other than "natural" the Medical Examine Completed by	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)   College (1-4 or 5+)   1 2   Disabled   N/A	
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than ic event, the Medica	Edward Cecil Tederick Pearl Melinda Henry	
MD 21 and 2 should alth and Me m 27 is ma anmatic ev	Shanna Lee Tederick/Daughter 655 S. Potomac St, #3, Hagerstown,	MD
Baltimore, permit, Pages I ar Department of Hee Important: If the Injury or other tr	20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State Final South Crem.  20b. Place of Disposition (Name of cemetery, place) Crem.  20c. Location - City or Town, State Woodbine, MD	<b>,</b>
	21. Signature of Funeral Service Licensee Dorota Marshall  22. Name and Address of Facility Maryland Cremation Services PO Box 1413, Baltimore, MD 2120  23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart  Approxim	) 3 nate Interval
Physician Medicul Examiner	failure. List only one cause on each line.  Immediate Cause (Final disease a. Atherosclerotic Cardiovascular Disease [Insert Park Park Park Park Park Park Park Park	n Onset and Death
10	Sequentially list conditions, b	
ted Insit Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):	
execur an and ai - tra	☑ UNPENDED ☐ AMENDED 23a,27 per me g912 2-18-11 vt	
Division of Vital Records, P.O. Box 68760, not the Bospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit edical Certification: To Be Completed by Physician/Medical Ex	FFEMALE:   23c. If yes, outcome of pregnancy   1	Year
i, P.O. I ires that the signed by the detached by the detached by the detached by the by Ph	1 Yes 2 ✔ No 3 Probably 4	
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the safer death.  al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detack the funeral To Be Completed by Pertification: To Be Completed by P	24a. Was an autopsy findir prior to completion of death?  1 ✓ Yes 2 No 1 ✓ Yes 2	of cause of
f Vital Physician: ar this certifral director, To Be (	25. Was case referred to medical 26.Place of Death (Check only one)  examiner?   Hospital	
ion of ' tending Ph eath. tor: After t the funeral		
Division o spital or Attending nours after death or filled in by the func Certification:	3 Suicide 6 Could not be determined (Specify)  28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State)  28f. Location (Street and Number or Rural Route Nor Town, State)	umber, City
Division  To the Hospital or Attent within 24 hours after death To the Funeral Director completely filled in by the Medical Certificati		
M F & F 2	29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Ye  O.C.M.E.  January 28, 2011	ar)
	30. Name and address of person who completed cause of death (Item 23a)  Donna M. Vincenti, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223	
State Registrar	The state of the s	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ FRNA Month 1534M 02 0661 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death BWMC len Kurnie nne utrunper 9. Birthplace (State or Foreign Country) Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Days 1 🗆 M 2 🗓 F Months Hours (Month, Day Director 87 280-40-3716 December 24, 1923 Czechoslovakia Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location with the Maryland the Medical Examiner must be notified at 10d. Inside City Limits Director Maryland 1 ☐ Yes 2 🛣 No Anne Arundel Severn 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? Funeral "natural", or items 23a 1912 Stonehearth Court 21144 United States 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ 1 ☐ Yes 2 ★ No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify: Completed 3 ₩ Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'amy injury or other traumatic event, the Meonee. Elementary/Seconday (0-12) College (1-4 or 5+) Manager Maintenance Facility Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည <u>Maximilian</u> Zechel Mathilde Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1912 Stonehearth Court, Severn, Maryland 21144 Gary W. Vogel/Son 20a. Method of Disposition February 3, 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Arundel Crematory 1 Burial 2 XCremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Odenton, Maryland 2011 M01386 Donaldson Funeral Home & Crematory, P.A.
1411 Annapolis Road, Odenton, Maryland 21113
Applications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,
one cause on each line. 21. Signature of Funeral Service Licensee . Part 1. Exter the disease, or dishock, or heart failure. List or Onset and Death Immediate Cause (Final Physician/ ongestive Heart disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence of: the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical or Attending Physician: The law requires that the death certificate be use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Dav 4 Pregnant 9 Unknown Pregnant at time of death be detached Division of Vital Records, P.O. by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed completed filled in by the funeral director, page 2 should peen 24a. Was an 24b. Were autopsy findings available After this certificate has autopsy performed prior to completion of cause of death? 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Yes မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? Natural 5 Pending injury Accident Investigation within 24 hours after deat To the Funeral Director: 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title 29c. License number 29d. Date signed (Month. Day, Year) Kenn 2890 mD. Name and address of person who completed cause of death (Item 23a) (Type, Print) lasthraten Medical Centers Glen Brushe MO Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Mogtan 30, D2011 1629 Kim Waldstreicher Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Annapolis Anne Arundel Anne Arundel Medical Center 5. Social Security Number If Under 1 Year | If Under 24 Hrs. . Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year, 9. Birthplace (State or Foreign **Funeral** 1 M 2 XX Months Days Country) **Director** 40 Feb 11, 1970 053-48-2240 Usual Residence of 28a-f show 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director MD Prince Georges Bowie 1 ☐ Yes 2 🕅 No ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral **23a** USA 20715 3411 Maple Bluff Lane Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces , or ; Black, White, etc. þ 1 X Never Married 2 Married 1 ☐ Yes 2 ☒ XNo If Yes, Give Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: White "natural" 3 Widowed 4 Divorced Completed Year or Dates al Hygiene. I other than "natura vent, <u>the M</u>edical E 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Administrative Assistant Transportation Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Pris marked o Joel S. Waldstreicher Blanche Brussel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 62834 E. Flower Ridge, Tuscon, AZ 85739 Blanche Walderstreicher f Health 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 Department of Important: If it cemetery, crematory or other place) 1 Burial XX Cremation XXX Removal from State Donaldson Crematory Feb 1, 2011 Odenton, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Ligansee any in 22 Name and Address of Facility Fink Funeral Home, P.A. M01148 426 Crain Hwy S., Glen Burnie, MD 21061 Part 1. Set the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Dehydration Physician/ disease or condition Medical resulting in death) Examiner nonex ca Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine burial-tran resulting in death) Last attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 Live Birth
4 Pregnant a 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy Day Year Pregnant at time of death Yes 2 No ed by the a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. s been signed by 23e. Did tobacco use contribute to the cause of death? Completed by etes Mellitus Records, 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No hrombaph/ebitis 24a. Was an has page 2 autopsy Yes 2 XN Hospital or Attending Physician: 1 24 hours after death. Funeral Director: After this certifics 25. Was case referred to medical examiner? Division of Vital funeral director. Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 🔀 Natural 2 🗌 Accider 5 Pending iniury Accident Investigation filled in by the Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 within 2 To the F only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certif 29d. Date signed (Month, Day, Year)

State

Registrar

MARDA LANE,

FWNAPOLIS.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Regis

NANCY D. RIVERA-KING

31. Date filed (Month, Day, Year,

7

January 31, 2011

			State of Maryland / Department of Health and N  1- State State Certificate of Death		giene	03107
	# 20 Sec.		1. Decedent's Name (First, Middle, Last)	2. Date of Dea	ath	3. Time of Death
4	Physici		Florence Margaret Willis	Januar	Day Year 7 31. 2011	10:30 A M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death		4c. County of Dea	
			7420 Westlake Terrace # 1206 Bethesda		Montgom	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.  1 0 0 0 0 2 0 0 0 1	8. Date of Birt (Month, Da)	v, Year) Co	thplace (State or Foreign ountry)
24	<ul> <li>Director</li> </ul>	8	109-09-3202 95 Yrs.	July 2	5,1915   Ne	w York
	yland		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	e Mar	ctor	Maryland Montgomery Bethesda			1 ☐ Yes 2 ☑ No
	or 28	Director	10e. Street and Number 10f. Zip Code		10g. Citizen of What C	ountry?
	ath w	E	7420 Westlake Terrace # 1206 20817		United Sta	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f ehow eny Injury or other traumatic event, the Medical Examinatinat must be notified at once.	by Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:	n Rican, etc.)		
20	72 ho	eted	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of work	king	16b. Kind of Business	/Industry
2	nithin ne.	Completed	Elementary/Secondary (0-12) College (1-4or 5+)		Own Hom	e
121	iled w tygier ther ti		12 Homemaker  17. Father's Name (First, Middle, Last)  18. Mother's Name	ne (First Middle	Maiden Sumame)	
anc	d be findal hed of	Be c		ce Doyle		
Maryland	should nd Me mark matic	P	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Ru			Zip Code)
S	alth all		Arthur Willis / Son 618 E. Floral Court B	rea, Ca	lifornia 92	2821
Baltimore,	Pages 1 anent of Heal	(8)	20a. Method of Disposition  1  Burial 2 Cremation 3 Removal from State  4 Donation 5 Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)  Gate of Heaven Cemetery 201	uary 8,	20c. Location - City of Silver Spr	Town, State
Balti	permit. Departn Imports eny Inju		21. Signature of Funefal Service Licensee  22. Name and Address of Facility Robert A. Pumphrey 7557 Wisconsin Aven	Funeral F ue Bethe	lome Bethesda- sda, Maryla	ChevyChase,Inc.
80	4 5 5 7 5 5 7 7		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.			Approximate Interval Between
nt-z	Physician		Immediate Cause (Final disease or condition			Onset and Death
×	/Medical Examiner	e l	resulting in death)  Due to (or as a consequence of):			
В	Examine	Ļ	Sequentially list conditions, frank leading to immediate b. Due to (or as a consequence of):			
	led	nine	if any, leading to immediate Due to (or as a consequence of): cause, Enter Underlying Cause (Disease or injury			
	cate be executed physician and the burial-transit	dical Examiner	that initiated events c. resulting in death) Last Due to (or as a consequence of):			
8760,	e be e	calE	d			
Θ	± 00 %					
.O. Box	res that the death certifi igned by the attending be detached for use as	ed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)		23d. Date of de Month	alivery Day Year
<b>a</b>	The law requires that the site has been signed by the bage 2 should be detache		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did t	obacco use contribute	to the cause of death?
rds,	quires n sigr			1 🗆 '	Yes 2 No 3□F	robably 4 [Unknown
Vital Record	s been si	Completed		24a. Was	an 24b. Were a	utopsy findings available
æ	The law	E o		autop perfo	ormed? death?	completion of cause of s 200 No
ital		To Be C	25. Was case referred to medical accordance 26. Place of December 27.	ath (Check only o		
	S 50		1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing H		dence 6 □Other (Sp	ecify)
Division of	ding Phy h. After thi funeral o	on:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 28a. Date of Injury 28b. Time of Injury 28b. Time of Injury 28c. Injury at Work?	28d. Describe	how injury occurred	
isio	ttend death stor: /	icat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office	28f Location (	Street and Number or F	Rural Route Number
Ď	after Direction by	Certification:	4 Homicide determined building, etc. (Specify)	City or To		
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical C	29a. Certifier (Check only one)  1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	and due to the irred at the time,	cause(s) and manner a date and place, and du	as stated. te to the cause(s)
)	To th within To th compl	Me	29b. Signature and title of certifier  Patricia Tomsko May, MD 29c. License number  DS1916		29d. Date signed (Mor Februari	nth, Day, Year)
	150		30 Name and address of person; who completed cause of death (Item 23a) (Type, Print) Patricia Tomsko Nay, 1119 Rockville Pike, G-100	Rock	ville m	D 20852
	Sta Registi		31. Date filed (Month, Day, Year)  FEB 0 7 2011  Aurua A. Aarus		/ / / / / / / / / / / / / / / / / / / /	

11-00569 Gail M. Wickers amend Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

San W. Wickers	1- For State Certificate of Begistrar		Reg. No.
Physician/	Decedent's Name (First, Middle,Last)	2. Dat Mo	te of Death 3. Time of Death
Medical Examiner	Gall II. Wickelb		nuary 20, 2011
	,	. City, Town, or Location of Death Glen Burnie	4c. County of Death  Anne Arundel
	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)		ate of Birth(MM/DD/YYYY) 9. Birthplace (State or
Funeral Director	50		v 14, 1957 Foreign Country) New York
	099-52-2293   1 M 2 K F   52 Yrs.  Usual Residence of Decedent		odalay,
Áu <b>t</b>	10a. State 10b. County 10c. City, Town or Location	1	10d. Inside City Limits
<b>₹</b>	MD Anne Arundel Glen Burn	ie	1 Yes 2 X No
daryland 28a-f show Lat once. ector		10f. Zip Code	10g. Citizen of What Country?
the Maryland to 28a-f shr tified at once	7923 Myers Drive	21061	USA
ss 23s c noti		Decedent of Hispanic Origin? ( Specify Y	
r death with or items 23 Const be no Funeral	1 X Never Married 2 Married Armed Forces? If Yes	, specify Cuban, Mexican, Puerto Rican,	etc.) White, etc.
ral", or		es 2X No specify:	Specify: White
ours a sami		Usual Occupation (Give kind of work do	ne 16b, Kind of Business/Industry
5-0036 ed within 72 hour 1/ygiene. other than "natti the Medical Exan	Elementary/Secondary (0-12) College (1-4 or 5+)	,	
withir in Medi	12 4 music		music  Middle, Maiden Surname)
15-1 filled Hyg deth	17. Father's Name (First, Middle, Last) Frank Wickers	Virginia D	
21215-0036 21215-0036 Jud be filed within 7 Mental Hygiene. marked other than ic event, the Medica TO Be Comple			oute Number, City or Town, State, Zip Code)
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland near of Health and Mental Hygiene.  ant: If item 27 is marked other than "natural", or items 23a or 28a-f shoor other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director		Banyan Dr; Maitlan	
and 2 and 2 sealth trem 2		on (Name of cemetery, Date	20c. Location - City or Town, State
it of it of the result of the	1 Burial XX Cremation 3 Removal from State crematory or othe		2011 Woodbine,MD
Baltimore, permit. Pages I an Department of He. Important: If ite	4   Donation 5 Extrample Specify: 111 Searce		
Baltimore, MD 2 permit. Pages I and 2 shoul Department of Health and M Important: If item 27 is mijury or other traumatic	21. Signatur of Euneral Serve Licensee	ryndAddescfemmy <del>State</del> 55 W. Baltimore St	DX 1713 Baltimore, MD 21201
Physician	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the		
/Medical	failure. List only one cause on each line.  Immediate Cause (Final disease a. Hypertensive Atherosc	lerotic Cardiovasc	D4
Examiner	or condition resulting in death)  Due to (or as a consequence of):	ISTOCIC OUTUIOVUSC	didi biscase
	Sequentially list conditions, b		
ed Insit Examiner	if any, leading to immediate Due to (or as a consequence of):		
G E	(Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):		
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760, cate be physici the buri	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the		23d. Date of delivery
68 certifi ding se as	past 12 months?  1 Live birth 2 Feta 4 Pregnant at time of death 5 Other	death 3Ectopic pregnancy	Month Day Year
b. Box 687 the death certific oy the attending ched for use as the	1 Yes 2 No 9 V Unknown 9 Unknown	(Specify)	
D. E	Part II. Other significant conditions contributing to death but not resulting in the un-	derlying cause given in Part I. 2	3e. Did tobacco use contribute to the cause of death?
P.C es that igned be deti			1 Yes 2 No 3 Probably 4 ✔ Unknown
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e law e has ge 2 sl			performed? death?  ✓ Yes 2 No 1 ✓ Yes 2 No
ifficat The S	25. Was case referred to medical	26.Place of Death (Check only on	
Division of Vital Records, P.O. ral or Attending Physician: The law requires that the rafter death.  1a Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach ertification: To Be Completed by Perfification: To Be	examiner?  1 ✓ Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatient	3 DOA Other Nursing Hom	e 5 Residence 6 V Other: Scene
of Vi g Physi fter this neral dir	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury	ury 28c. Injury at Work? 28d. D	Describe how injury occurred
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r Atta r Atta ter de irrecte n by t	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street,		ocation (Street and Number or Rural Route Number, City
Division o spital or Attending tour steer denth.  Beral Director: Affilled in by the fune	4 Homicide determined (Specify)		r Town, State)
Hosy 24 hc Fun stely 1	29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death occurred		
Division of Vital Records, P.O. Box 68760,  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans Medical Certification: To Be Completed by Physician/Medical E	one) 2 Medical Examiner: On the basis of examination and/or investigation and manner stated.		
عَ الْمَامِ عَلَمَامِ	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	Unes Z	O.C.M.E.	January 21, 2011
	30. Name and address of person who completed cause of death (Item 23a)	nore Street Politimers MD 245	223
	Ana Rubio MD. Assistant Medical Examiner 900 W. Baltin  31. Date filed (Month, Day, Year)  32. Date filed (Month, Day, Year)		
State Registrar			
DHMH 17 Rev 1/2001	ORIGINAL	OCA	ΛΕ

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
 Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Irene** Physician/ C. Wade 2 0 1 1 Medical 10:50 Mm January 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death Clinton4c. County of Death Prince George' Suburban Hospital **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) 148-36-7119 1 □ M 2**X** F Months Days Hours 49 (*Month, Day, Year)* 07/31/1931 Director Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must has nevertined. 10a. State 10b. County Funeral Director 10c. City, Town or Location 10d. Inside City Limits MD Prince George Fort Washington 1 🎽 Yes 2 🗌 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20744 7505 Bellefield Avenue 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Yes 2 No
If Yes, Give
Year or Dates. Completed by 1 Never Married 2 Married Black, White, etc. Baltimore, Maryland 21215-0036 3★ Widowed 4 Divorced 1 ☐ Yes 2 K No Specify: Black Specify 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) 1 2 Homemaker Own Home Be Father's Name (First, Middle, Last)
Thomas Lee Dowell 18. Mother's Name (First, Middle, Maiden Surname)
Magnolla Lester ည 19a. Informant's Name/Relationship (Type, Print) . Informant's Name/Relationship (Type, Print)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State,
136 Nelson Ave., Fayettville, NC 28314 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 🗆 Burial 2 🖾 Cremation 3 🗆 Removal from State cemetery, crematory or other place)
Final Journey crem. Woodbine, MD 4 Donation 5 Other (Specify) 2/4/2011 21. Signature of Funeral Service Licensee Dorpta Marshall Maryland Cremation Services PO Box 1413, Baltimore, MD21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on unclassified Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) attending physician and for use as the burial-transit resulting in death) Last Due to (or as a co Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No 3 ☐ Ectopic pregnancy5 ☐ Other (specify) \_\_\_ Pregnant at time of death Month Day Year be detached signed by the g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, To the Hospital or Attending Physician: The law requires within 24 hours after death.

To the Puneral Director: After this certificate has been sign completed filled in by the funeral director, page 2 should be Completed 1 Yes 2 No 3 Probably 4 Hinknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy perform 1 ☐ Yes 2 **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital မ 2 1 No 1 Inpatient Other: 2 ER/Outpatient 3 DOA 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) Certificate: 27. Manne - Leath 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Natural work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 28f. Location (Street and Number or Rural Route Number. City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Pragriculer: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) and address of pe death (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Month. Dn

32. Re

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of M	arylan					and M	lental Hy	giene	2011		2110
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4	Physicia		T. 5000donto Namo (1 115t, Middle, Ede	,	Louis	se Your	a				Month Februar	Da		2:1	ne of Death
	Medic Examir		4a. Facility Name (if not institution, give		поить	oc Tour		own, or I	Location o		rebruar		. County of Dea		10 p
	ŧ.		600 7th Street	·			Lau	_					rince G		
	Funeral		5. Social Security Number 6. S		e (In yrs. I	ast birthday)	If Under Months		If Under 2	24 Hrs. Min.	8. Date of Birl	th	9. B	irthplace (St	ate or Foreign
ı.	Director		577-34-3055	□м 2Х Г	82	Yrs.	MOULTS	Days	Hours	IVIII I.	June 3	0, 1	.928 Was	shingt	on, DC
	how at	<u>_</u>	Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Lo	ation							10d. Insid	de City Limits
	anylar la-f s ified	Director	MD Prince	George		irel									Yes 2 No
	or 28		10e. Street and Number	dedige	Бас	ilei	10f. Zip (	Code				10g. Ci	tizen of What C	Country?	
	with s 23a ust b	Funeral	600 7th Street				207	07				U.S	S.A.		
	leath items ier m	뎚	11. Marital Status	12. Was Decedent I Armed Forces?	ver in U.S	3. 13. V	Vas Decede Yes, specif	ent of His	panic Orig	gin? (Spe	cify Yes or No-		14. Race - Am		n,
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lan	shoul and l is m	. 13	19a. Informant's Name/Relationship (T)	/pe, Print)		19b. Mailin	g Address (	Street ar	nd Numbei	r or Rura	Route Numbe	r, City or	Town, State, Z	(ip Code)	
≥,	ind 2 lealth m 27 her tr			daughter					ve,	#63,	Dickin	son	Texas	77539	)
Baltimore, Maryland 21215-0036	Je 1a t of H If ite or otl		20a. Method of Disposition 1   Burial 2   Cremation 3	Removal from State		Place of Disporemental Place of Disporemental			)		ate	20c. L	ocation - City o	r Town, Stat	е
ţ	t. Pag ntmen rtant njury		4 Donation 5 Other (Specif		0a	kwood					10, 11	Fa]	lls Chu	rch, V	/irginia
Ba	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	l li	21. Signature of Funeral Service icons	L	M00	773 3	Name and onald 13 Ta	Address Son 1bot	of Facility Fune: t Ave	ral :	Home, P	.A. Mary	land 2	0707-4	1389
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Box 687	requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Physician/Medical	200. Was decedent pregnant	23c. If yes, outcome 1  Live Birth			Ectopic pr	egnancy					23d. Date of de	elivery	
B0)	death ne att ed for	sici	in the past 12 months? 1  Yes 2 No	4 Pregnant a			Other (spe						Month	Day	Year
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Division of Vital Records, P.O.	es tha	t by	Carotid Stenosis	ontributing to death b	ut not les	alting in the di	idenying ca	use give	ii iii Faiti.				ıse contribute t ☐ No 3 ☐ I		
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m	r: The ficate r, pag	ပ္ပ	25. Was case referred to medical			<u> </u>					1 \( \text{Yes}	2 X N		es 2 No	
lita	<b>hysician:</b> The lar nis certificate ha I director, page 2	o Be	examiner?	Hospital:		FD/0:	D PO	LOther	e of Death						
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isi.	I or Attend after death Director: /	Certificate:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju	iry - At ho	me, farm, stre	et, factory,	office		2	28f. Location (S City or Tow		d Number or Ri	ural Route N	umber,
<u>S</u>	ital or Irs aft ral Dir led in									- 1					
	To the Hospital or Attending Physician: The law requires that the death certificat within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phycompleted filled in by the funeral director, page 2 should be detached for use as the completed filled in by the funeral director, page 2.	Medical	29a. Certifier 1 X Certifying Physic (Check 2 Medical Examionly one) 3 Certifying Nurs	ner: On the basis of e	xamination	and/or investi	gation, in m	y opinion	, death occ	curred at	the time, date a	nd place	, and due to the	cause(s) and	d manner stated.
	fo the vithin fo the sompl	Σ	29b. Signature and title of certifier	e Fractioner; To the	Dest Orm	/ Knowledge, d		License r		and place			te signed (Mon		)
			> Leller ()	Hell			10	00	58	60		,	2/3	///	
	1		30. Name and address of person who d	ompleted cause d	eath (Item	23a) (Type, P					, 1		-/-/	. 1	
	1		Kelly Tanenholz,	M.D. 14	999	Health	Cent	er D	rive,	Ste	201,	Bowi	e, Mary	yland	20716
	Stat Registra		31. Date filed (Month, Day, Year) FEB 0 7 2011	32. Registra	ar's Signat	well									
	negistra	al .	FEDUI CUIT CA	want by.											

DHMH 17 Rev 7/2009

Division of Vital Records, P.O. Box 68760

**Physician** 

Examiner

Funeral

Director

28a-f show

ral", or items 23a or 28a-f shore

"natural", or items 23a

Director

Funeral

þ

Completed

/Medical

Pages 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene.
Int: If item 27 is marked other than "natural", or ite Baltimore, Maryland 21215-0036 Be မ 19a. Informant's Name/Relationship (Type. Print) Mrs. Joy Yap Smith/daughter permit. Pages 1 and Department of Healt Important: If item 27 any Injury or other 1 once. 20a. Method of Disposition

1 → Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Furleral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine attending physician and for use as the burial-transi Hospital or Attending Physician: The law requires that the death certificate be executed Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Completed certificate 25. Was case referred to medical examiner? Be 1 ☐ Yes 2 ☐ Mo Certification: To this 27. Manner of Death After 1 Natural nours after death.

neral Director: Aff
y filled in by the fur 2 Accident 3 ☐ Suicide 4 Homicide To the Hospital within 24 hours a To the Funeral C 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of centifier ATTENDING PHYSICIAN 29c. License number 29d. Date signed (Month, Day, Year) FEBRUARY 10062239 2011 DR HAW. NAING 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2 00, NAING MD MAW . 5601 Loch Raven Boulevard, Baltimore MD 21239 31. Date filed (Month, Day, Year) Begistrar's Signature FEB 0 7 2011 Registrar DHMH 17 Rev 1/2001 ORIGINAL.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State	State of Ma	ryland		rtment of F						
	-1	Registrar  1. Decedent's Name (First, Middle, La	ist)			lilicale of	Deau		Date of Deat	eg. No. 2		3. Time of Death
Physicia		Nancy Ath	erton						Month San Ucy	Day 18	Year ZOII	12:04 PM
/Medic Examin		4a. Facility Name (# not institution, give	e street and number)			4b. City, Town, o		n of Death	9	4c. County	y of Death	
		Mercy Medical	C - 10				MON					
Funeral		5. Social Security Number 6. 9 6. 9	I N ON I	(In yrs. lasi	t birthday) . Yrs.	If Under 1 Year Months Days	If Unde Hours	Min.	Date of Birth (Month, Day,	Year)	Coui	place (State or Foreign ntry)
Director		Usual Residence of Decedent		59	110.			A	ug. 14	,1941	Mary	Land
ryland thow	_	10a. State 10b. County		10c. City, T	own or Loc	ation					-	10d. Inside City Limits
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or Iten		1 ☐ Never Married 2 ☒ Married	Armed Forces? 1 ☐ Yes 2 🛣 No			Vas Decedent of H Yes, specify Cuba			can, etc.)	Bla	ck, White,	etc.
215-0036 thin 72 hours after death with the Maryland le. ian "natural", or Items 23a or 28a-f show Modical Examican investors at the standard at	d by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		'	□Yes 2XXNo	Specif	ry:		Specif	y: Wh	ite
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C 20 14 F		Walter Atherton-1 20a. Method of Disposition	nusband	20h Blac	13528	Donnybr	ook ]	Dr. Hag	gersto	vn, MD	2174	2 Ourn State
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Baltimore, permit. Pages 1 ar Department of Hec Important: If Item any injury or othe		4 ☐ Donation 5 ☐ Other (Special 21. Signature of Funeral Service Lice	<del></del>	DOOL		Name and Addre		1-22-2	2011   Γ	Fierv	Fune:	Maryland
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Attending ar death. ector: Afte	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day,	Year)	Injury		k? Yes 2[	□No				
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DHMH 17 Rev 1/2001

			For State		State of Ma	aryland		artment of F ctificate of a		Mental Hy			
	-		Registrar  1. Decedent's Name (Fi	irst Middle Last				lilicate of t	Dealii	2. Date of De	Reg. No.,	2011	3. Time of Death
	Physicia		Audrey Ma							Januar Januar	Day	2011	2:38 p M
	/Medic Examin		4a. Facility Name (If not					4b. City, Town, o	r Location of Death		_	County of Deal	
	Xaiiiii	€/61	Harrison S	enior Li	vina			Snow Hil	1		Wo	rceste	<u> </u>
	Funeral		5. Social Security Numb	er 6. Sex		e (In yrs. las		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D	ay, Year)	9. Birt	thplace (State or Foreign ountry)
	Director		157-18-981	3	INI ZLXI	84	Yrs.			May 7,	1926	Mary	yland
3	and t		Usual Residence of Dec 10a. State 10i	b. County		10c. City,	Town or Lo	cation					10d. Inside City Limits
	Mary -f sh ijed a	to	MD W	orcester		Pocon	noke C	itv					1 □Yes 2√□ No
	r 28a r notii	iec	10e. Street and Number			10001	ione c	10f. Zip Code			10g. Citiz	en of What Co	ountry?
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1	illed within 72 nours after death with the Maryland Hygiene. tither than "natural", or items 23a or 28a-f show int, the Medical Examiner must be notified at	Funeral Director	11. Marital Status		12. Was Decedent I Armed Forces?		. 13. \	Was Decedent of H If Yes, specify Cub	lispanic Origin? (S an, Mexican, Puerl	pecify Yes or No o Rican, etc.)	0- 1	<ol> <li>Race - Ame Black, Whit</li> </ol>	
o ၁	s arre	by Fu	1 ☐ Never Married 3 🏿 Widowed 4 ☐		1 ☐ Yes 2 🔼 N If Yes, Give Year or Dates:	No		1 ☐ Yes 2 🔀 No	Specify:			Specify: wh	ite
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Mar	2 sh and is m raum		19a. Informant's Name		,			ng Address (Street					
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	150		23a. Part1. Enter the d	lisease, or compl	ications that caused ne cause on each lir	the death.							Approximate Interval Between
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,	/Medical		resulting in death)		Due to (or as				, - ,-				
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	isit is	ine	if any, leading to immedause. Enter Underlyin Cause (Disease or injure)	IU	Due to (or as	a conseque	ence or):						
	xecul and al-trar	Examiner	that initiated events resulting in death) Last		Due to (or as	a conseque	ence of):						
8/00,	ficate be executed physician and sthe burial-transit	dical			١								
00	tificati ig phy as the	ledi											
Š .	th cer endin r use	sician/Me	IF FEMALE: 23b. Was decedent pre	egnant	3c. If yes, outcome 1□Live birth			∃Ectopic pregnanc	:v		2	23d. Date of de Month	elivery Day Year
	w requires that the death certin been signed by the attending should be detached for use as	sicia	in the past 12 mo 1 ☐ Yes 2 ☑ No		4□Pregnant at 9□Unknown			Other (specify)				MOULL	Day Fear
7.	d by t letach	Phys	9 Unknown ` Part II. Other significa	nt conditions co	ntributing to death h	ut not resul	ting in the u	nderlying cause giv	ven in Part I.	23e. Did	tobacco u	se contribute t	to the cause of death?
Sp.	signe signe	by	Tait ii. Other algimou.	ne containe oo	naibuang to occur b	d: 1101 100d/		nasnying saass gr	V 4.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1.1	1 🗆	Yes 2	No 3□F	Probably 4 □Unknown
Ö	requ been should	etec								24a. Wa	e an	24h Were a	utopsy findings available
Records,	The law cate has b page 2 sl	Completed								aut per	opsy formed?	prior to death?	completion of cause of
_ '		e Co	25. Was case referred	to medical					26. Place of De	1  Yes ath (Check only		1 □Ye	s 26 No
	Physician: this certific ral director,	o B	examiner? 1 ☐ Yes 2 No	r-	Hospital: 1 ☐ Inpatie	ent 2 □ E	R/Outpatie	nt 3 DOA Oti	her: 4 Nursing I			6 □Other (Sp	ecify)
ם י	ig Ph ter thi	n: T	27. Manner of Death	5 ☐ Pending	28a. Date of Inju		28b. Time o		ry at	28d. Describe			
000	Attending r death. ector: After by the funer	atic	2 Accident	investigation					Yes 2 □ No		_		
DIVISION	or Att fter de Sirect n by t	Certification:	3 ☐ Suicide 6 4 ☐ Homicide	determined	28e. Place of inj building, et	ury - At hor tc. (Specify)	ne, farm, st	reet, factory, office			(Street an own, State		Rural Route Number,
ַ ב	spital or Attending Physions after death.  neral Director: After this filled in by the funeral di		29a, Certifier 1	artifying Phy	sician: To the best	of my know	/ledge. deal	th occurred at the t	ime, date and place	e. and due to th	e cause(s)	and manner a	as stated.
:	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the t	Medical	(Check only 2 one)	Medical Exam	iner: On the basis of and manner st	of examinati	on and/or ir	nvestigation, in my	opinion, death occ	curred at the tim	e, date and	d place, and du	ue to the cause(s)
;	To the Hos within 24 h To the Fur completely	Me	29b. Signature and title	e of certifie	1011			_	se number		1		nth, Day, Year)
				20	Mm mD	)		D	0062172	2	1/	20/201	1
			30. Name and address	of person who c	ompleted cause of c	death (Item	23a) (Type,	Print)		c (A:	140 0	16=1	
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	Sta		31. Date filed (Month,			rar's Signat		1					
	Registi	al	J	ANZIZ	011 Jenes	une,	B. A	arke					

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2011 10:55 AM James Esley Brown January Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Prince George's 6804 Seat Pleasant Drive Seat Pleasant 8. Date of Birth (Month, Day, Year) May 12, 1949 Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Min. 1 ፟ M 2 ☐ F Months Davs Hours Country) Director 61 DC 577-66-5130 May Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits Director ral", or items 23a or 28a-f s Examiner must be notified 1 X Yes 2 ☐ No Capitol Heights Maryland Prince George's 10e. Street and Numbe 10f Zip Code 10g. Citizen of What Country? Funeral 20743 United States 6804 Seat Pleasant Drive 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces? Black, White, etc. à 1 X Never Married 2 Married within 72 hours after Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 ☐ No Specify. If Yes. Give 3 Divorced 4 Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Laborer Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F မ Department of Health and Ment Important: If item 27 is marked any injury or att Pernell Brown Annie Berry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20772 12219 Westview Drive Upper Marlboro, Maryland <u> Shirley A. McGill - Sister</u> 3altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State January 20, 4 Donation 5 Other (Specify) Resurrection Clinton, Maryland 2011 -22. Name and Address of Facility Stewart Funeral Home, Signature of Funeral Service 20019 4001 Benning Road NE Washington, DC Part 1. Let the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoot a learn failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Malignant Cardiac Arrhythmias Medical resulting in death) Due to (or as a consequence of) Examiner Atrial Fibrillation Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence of burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Dav Year signed by the a 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Chronic Obstructive Pulmonary Disease Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown peen Were autopsy findings available prior to completion of cause of 24a. Was an Obstructive Sleep Apnea page 2 s has autopsy death? certificate Diabetes Mellitus 2 🔯 No 2 🗌 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical of Vital 읆 26. Place of Death (Check only one) 1 Yes 2 X No Other: ၉ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 🗵 Residence 6 ☐ Other (Specify) funeral ( 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred eral Director: After filled in by the funer 1 XNatural 5 Pending work? 1 ☐ Yes 2 ☐ No Division Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical ☑ Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier To the Fune completed fi (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20770 Rexford A. Babilah, M.D. 7500 Hanover Parkway Greenbelt, Md. 31. Date filed (Month, Day, Year) 82. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

JAN 1 9 2011

parke

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 8:50 am 2011 Peter Domenick Bonin January Medical 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Holy Cross Hospital Silver Spring Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs. 8. Date of Birth Funeral 1 **X** M 2  $\square$  F Months Days Hours 14072471924 Idaho 86 Director 519-18-0556 Usual Residence of Decedent items 23a or 28a-f show ler must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location within 72 hours after death with the Maryland Director 1 Yes 2 X No Silver Spring Maryland Montgomery 10f Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 20910 u.s.A. 1400 Flora Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Examiner ed Forces?
Yes 2 No 0 þ 1 Never Married 2 X Married X Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: White "natural" Completed 3 Widowed 4 Divorced WWII the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) Association of permit. Page 1 and 2 should be filed within 7: Department of Health and Mential Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me College (1-4 or 5+) Elementary/Seconday (0-12) American Railroad Assistant Director 5+ Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Mary Codogno Domenick Bonin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1400 Flora Lane. Silver Spring, Maryland 20910 Geraldine L. Bonin - Spouse 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place 1 Burial 2 X Cremation 3 Removal from State Lincoln Crematory 01/31/2011 | Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Vicensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Acute Mental Status Change disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Pulseless Electrical Activity Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and eted filled in by the funeral director, page 2 should be detached for use as the burial-thans. the attending physician and hed for use as the burial-than that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Year Month Day Pregnant at time of death Unknown 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 2 🗌 No 1 Yes 1 🗌 Yes 2 💢 No Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 🗓 No မှ 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 2 ☐ No 1 X Natural 5 Pending Accident Investigation ☐ Acciue
☐ Suicide 6 Could not be To the Hospital or Atte within 24 hours after de To the Funeral Directo completed filled in by th 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 🗵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and the of certifier 10+1 alaye D006+2 Januaru 22. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1500 Forest Glen Road, Silver Spring, Maryland 20910 M.D., Suganthi Alagarsamy, 31. Date filed (Month, Day, Year) 32 Registrar's Signatur State

Registrar

JAN

State of Maryland / Department of Health and Mental Hygiene / Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year 2011 Physician/ THERINE 080V M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Anne Arundel 1831 Crofton Parkway Apt. D Crofton If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Social Security Number 6. Sex 7. Age (In yrs. last birthday) Country) Oregon Days 1 🗆 M 2 🗷 F Hours Min. Months 10/12/1947 Director 016-40-9038 63 Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10b. County 10d, Inside City Limits 10a. State 10c. City, Town or Location Director 1 Yes 2 X No Crofton MD Anne Arundel 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral USA 21114 1831 Crofton Parkway Apt. D 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married þ Yes 2 No Yes, Give 1 ☐ Yes 2 X No Specify: Completed Specify: White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Real Estate Agent 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Scharon Donald Gigger Lorraine 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1831 Crofton Parkway Apt. D, Crofton, MD 21114 <u> Joseph Edwin Bridenstine,Sr/Spouse</u> item 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or'ot 1 Burial 2 Cremation 3 Removal from State 1/19/2011 Metro Crematory Baltimore, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy., Bowie, MD 20715 23a. Part 1. Enter the disease, or compile cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only ause on each line Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last certificate be executed burial-transi and Due to (or as a consequence of): physician Physician/Medical use as 1 the attending IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No signed by the atte Month Dav Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe After this certificate 1 Yes 2 No Yes Hospital or Attending Physician: 25. Was case referred to medical funeral director. Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending s after death. 1 Yes 2 No Accident
Suicide Investigation 6 Could not be completed filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Funeral I Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check To the lawithin 2 29b. Signature and title of certification 29 Date signed (Month, Day, Year) 20 who completed cause of death (Item 23a) (Type, Print) 31. Date filed (MOJA N. 1 9 2011 Registrar's Signati Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

21215-0036

Baltimore, Maryland

Box 68760

Records,

of Vital

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For AMBUD#11 Per PHY State of Mary State of Mary AACO Health Dept. CMH Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Fobler 2. Date of Death 3. Time of Death Physician/ 9:30 P January 201 T Arthur Fobe Bates Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Mandrin Chesapeake Hospice House Harwood Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 **X**XM 2 □ Days Hours Min M971171915 New York 103-07-1501 **Director** 96 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2XXNo Maryland | Prince George's Largo 10e, Street and Number 10f. Zip Code ŏ 10g. Citizen of What Country? ral", or items 23a o Examiner must be Funeral 10137 Prince Place #401 20774 USA within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 XNo Black, White, etc. 1 Never Married 2XXMarried "natural", or ð Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2xxx No Specify: Specify: Black Completed 3 Widowed 4 Divorced the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 Popartment of Health and Mental Hygiene. Important: If item 27 is marked other than "ne any injury or other traumatic event, the Media. (Specify only highest grade completed) (Give kind of work done during most of working College (1-4 or 5+) life. DO NOT use retired) Elementary/Seconday (0-12) Police Officer New York City Transit years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Arthur S. Bates K.L. Marie Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10137 Prince Place #401 Largo, Maryland Annie P. Bates Wife 20774 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 1/26/2011 Clinton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Resurrection Cemetery 22. Name and Address of Facility George P. Kalas Funeral Home PA If Funeral Seville Lices 21. Signatu alla 6160 Oxon Hill Road Oxon Hill, Maryland 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Molichant Physician/ Megabsm disease or condition resulting in death) Medical Due to (or as a nsequence of) **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to lor as a consequence of the attending physician and hed for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year Pregnant at time of death 5 Other (specify) 1 ☐ Yes ∠ ☐ 9 ☐ Unknown this certificate has been signed by the ral director, page 2 should be detached Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No 1 Yes 2 🗆 No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Hospital Other: Hospice 1 🗌 Yes 2 🔀 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 N Other (Sp 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred M Natural (Month, Day, Year) 5 Pending n 24 hours after death.

e Funeral Director: After the function of the functin 1 Yes 2 No ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined Medical 29a. Certifier 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, dearn occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the P within 2 To the F 29b. Signature and title of certifier 29c, License number A 21925 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9560 Penn the Suit 202 Upper Mariboro Md 2077 Perkins MO 31. Date filed (Month, Day, Year) State **JAN 19** Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** Januar 2011 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Baltimore City The Johns Hopkins Hospital Date of Birth (Month, Day, Year) 6-24-1936 Birthplace (State or Foreign Country)
 WV Social Security Number . Age (In vrs. last birthday **Funeral** 218-30-8692 74 1 □XM 2 □ F Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f shov Examiner must be notified at Hagerstown MD Washington 1 ☐ Yes 2X No Director 10f. Zip-Code 10g. Citizen of What Country? 10e. Street and Number ö 21740 U.S.A. 11832 Walnut Point Road items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1X Yes 2 Nd 953—
If Yes, Give Year or Dates: 1956 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married white Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 ☐ No Specify Completed by Specify 3 X Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) federal govt. Elementary/Secondary (0-12) College (1-4 or 5+) than Hygiene. supervisor 12th grade marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fill ment of Health and Mental Hitant: If item 27 is marked oth Be Jane Hatter Paul Braithwaite Sr. Lucy ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) daughter 11822 Walnut Point Rd. Hagerstown, MD 21740 Christie Ecton item 2 Date 26, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Hagerstown, MD Jan . 2011 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Department of Important: If it any injury or o Cedar Lawn Cem. 22. Name and Address of Facility
Donald Edwin Thompson Funeral Home, 21. Signature of Funeral Service Licensee MO1414 Lee PO BOX 310 Clear Spring, MD 21 722

Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate Part 1. Enter the disease, or complications that caused the death. Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner certificate be executed ician and burial-trans Due to (or as a consequence of) Box 68760, attending physician Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 - Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Vear detached for Pregnant at time of death 5 Other (specify) 2 🗌 No 9 Unknown Division of Vital Records, P.O. the 9 I Inknown been signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 **X** No 3 Probably 4 Unknown 1 ☐ Yes Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗌 No Yes 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Inpatient 6 Other (Specify) မ this 28a. Date of Injury (Month, Day Year) Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation Injury or Attending 1 Tes 2 🗌 No death. filled in by the after death 6 Could not be determined 3 🗌 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation is examined. To the Hospital within 24 hours a To the Funeral C Hospital 29a. Certifier Medical (check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) X45-000 January 22, 2011

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month

600 North Wolfe St, Baltimore, MD, 21287

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Nayor

Registrar's Signature

7	Examir
	Funeral Director
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician/ Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760

	•	State Registrar	(	Certificate of De	eath	Reg. No.	03119
Physicia Medic		1. Decedent's Name (First, Middle, Last)  DORIS, LORRALI	NE, BEMI	ISDERFER	2. Date of Month	Death  Day  Year  20 20	3. Time of Death 9: 35 A M
Examin		4a. Facility Name (if not institution, give street and Meritus Medical Cent		4b. City, Town, or Lo		4c. County of Dea Washing	
Funeral Director		5. Social Security Number 6. Sex 1 M 2 X	7. Age (In yrs. last birtho	day) If Under 1 Year I	f Under 24 Hrs. 8, Date of	Birth 9. Bir	thplace (State or Foreign untry)
Ba-f show lifled at	Director	Usual Residence of Decedent  10a. State 10b. County PA Franklin	10c. City, Town of				10d. Inside City Limits 1 ☐ Yes 2 🏋 No
s 23a or 2 ust be no	Funeral Di	10e. Street and Number 11650 Bemisderfer Roa	d	10f. Zip Code 17225	5	10g. Citizen of What Co	-
Department of Health and Mental Hygiene. Important: I fitem 273 or 28a-f show Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	1 Never Married 2 Married 1 Never Married 1 If Yes,	Decedent Ever in U.S. If Forces? Yes 2 X No Give or Dates.	13. Was Decedent of Hisp If Yes, specify Cuban, 1 ☐ Yes 2 No	anic Origin? (Specify Yes or N Mexican, Puerto Rican, etc.) Specify:		
iene. rr than "nat the Medica	Completed	15. Decedent's Education (Specify only highest grade comple Elementary/Seconday (0-12) Colleg	e (1-4 or 5+)	Decedent's Usual Occupation  Give kind of work done durifie.  DO NOT use retired)		16b. Kind of Business	Industry salon
nental Hyg rrked othe tic event,	To Be	17. Father's Name (First, Middle, Last)  James Monroe Lynch		1	8. Mother's Name (First, Midd Hazel Doughe	dle, Maiden Surname)	
alth and M 27 is ma r trauma		19a. Informant's Name/Relationship (Type, Print)  Jacob G. Bemisderfer J	1		Number or Rural Route Num erfer Road (	nber, City or Town, State, Zi	
nent of Hea nt: If item ry or othe		20a. Method of Disposition 1 ☐ Burial 2 【X Cremation 3X】 Removal t 4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of E cemetery,	Disposition (Name of crematory or other place)	Date rem. 01/25/20	20c. Location - City or	Town, State
Departm Importa any inju once.	Ì	21. Signature of Funeral Service Licensee	sul-	22, Name and Address	of FacilityMiller-Bo	wersox Funer	al Home
ysician/		23a. Part 1. Enter the disease, or complications to shock, or hear failure. List only one cause of Immediate Cause (Final disease or condition	n each line.	t enter the mode of dying, s			Approximate Interval Between Onset and Death
Medical xaminer	<u>_</u>		SEPSIS to (or as a consequence of) NEUMO(	_			
າ and al-transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events c.	to (or as a consequence of)				
ng physician and as the burial-transit	Medical	<b>L</b> d					
_ ds	< I	in the past 12 months?	outcome of pregnancy Live Birth 2  Fetal death Pregnant at time of death Unknown	3  Ectopic pregnancy 5 Other (specify)		23d. Date of de Month	ilivery Day Year
en <b>s</b> igned by Juld be deta		Part II. Other significant conditions contributing ESRD, CHRON	to death but not resulting in	the underlying cause given	- 1	d tobacco use contribute to	
ate has bee page 2 sho	Completed by	NARYHTN THRO	OM BOCYT SPLANT	OPENIA,	pe	as an 24b. Were au prior to death? es 2 1 No 1 Yes	ntopsy findings available completion of cause of
certific rector,	Be	25. Was case referred to medical examiner?  1  Yes 2 No Hospital:		_ Other:	of Death (Check only one)		
ath. r: After this ie funeral di	Certificate: To	27. Manne of Death  1 ☑ Natural 5 ☐ Pending 2 ☐ Accident ☐ Investigation	Inpatient 2 ER/Outplate of injury 28b. Tin Injury I	ne of 28c. Injury at work?	4 Nursing Home 5 R 28d. Describ	esidence 6 U Other (Spec be how injury occurred	ify)
rs after de al Directo ed in by th			ace of Injury - At home, farm uilding, etc. (Specify)	n, street, factory, office		n (Street and Number or Ru Town, State)	iral Route Number,
nin 24 hou t <b>he Funer</b> npleted fill	Medical	29a. Certifier (Check only one)  1 Certifying Physician: To the Check only one)  1 Certifying Nurse Praction	basis of examination and/or i	investigation, in my opinion,	death occurred at the time, da	te and place, and due to the	cause(s) and manner stated.
viti con		29b. Signature and title of Stuner	M.D.	29c. License nu	65024	29d. Date signed (Mont	h, Day, Year)
3		30. Name and address of person who completed of MDNIQUE GO	MA 111	rpe, Print) 16 Medica	65024 Langus R	d. Hagersti	WN,MD 42
Stat Registra	e	31. Date filed (Month, Day, Year) 3	2. Registrar's Signature	backer	,		

11-00844 Addie Marie Brown

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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		1- For State Certificate of Death Registrar	critai riygiciic	Reg. No.	
Physici dical Exam		Decedent's Name (First, Middle,Last)	Date of Month	Day Year	3. Time of Death 1128 hrs
Dicai Exam	mer	4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location		ry 30, 2011 4c. County of Deat	
		Shady Grove Adventist Hospital Rockville		Montgomery	
Funeral Director			ours Min	of Birth (MM/DD/YYYY) 9. Bi	
nd show any ice.	10	10a. State 10b. County 10c. City, Town or Location VA Rock Bridge Fairfield			10d. Inside City Limits 1 Yes 2 No
the Maryland as or 28a-f show otified at once.	Director	10e. Street and Number 6310 North Lee Hwy. 24435		10g. Citizen of What Cou	intry?
Imore, MD 21215-0036  Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.  Gant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once.	y Funeral	11. Marital Status 1 Never Married 2 Married    12. Was Decedent Ever in U.S.   Armed Forces?   1 Yes 2 No    3 Widowed 4 Divorced If Yes, Give Year    13. Was Decedent of Hispanic C   If Yes, specify Cuban, Mexic	ican, Puerto Rican, etc.		rican Indian, Black,
36 in 72 hours a han "natura ical Examin	Completed by	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  7th  College (1-4 or 5+)  Cafeteria Worke	NOT use retired)	16b. Kind of Business	/Industry
215-0036 be filed within 7 atal Hygiene. rked other than ent, the Medica	Be Com	17. Father's Name (First, Middle, Last)	ther's Name (First, Mid ttie Chri	dle, Maiden Surname)	
MD 2121 d 2 should be fi th and Mental in a 27 is marked numatic event,	2	19a. Informant's Name/Relationship (Type, Print)  JoAnn Merchant/Daughter  19b. Mailing Address (Street and North Lee	e Hwy.Fai	rfield, VA 2	24435
Baltimore, MD 2 permit. Pages 1 and 2 shoul Department of Health and N Important: If item 27 is minjury or other traumatic			2/5/201	20c. Location - City of 1 Steeles T	avern,VA
Balt permit Depart Impor	j.	21. Signature of Funeral Service Licensee  22. Name and Address of Face  23. Name and Address of Face  24. Name and Address of Face  25. Name and Address of Face  26. Name and Address of Face  27. Name and Address of Face  27. Name and Address of Face  28. Name and Address of Face  29. Name and Address of Face  20. Name and Address of	shington	Rd.Waldorf	
Physician /Medical xaminer		failure. List only one cluse in each line.  Immediate Cause (Final disease a. <b>Hypothermia</b>	as cardiac or respirator	y errest, shock, or near	Between Onset and Death
	-	or condition resulting in death)  Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):  Environmental Cold Exposure  Due to (or as a consequence of):			
ted 1 insit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  C.  Due to (or as a consequence of):  d.			
1760, ficate be executed g physician and the burial - transit	Medical	■ AMENDED 23a,pt.II,27,28a-f per me	e g914 4-4-		
Box 6876 he death certificat the attending ph	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1	topic pregnancy	€	Day Year
rds, P.O.	à	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Alzheimer's Dementia, Hypertensive Cardiovascu		Oid tobacco use contribute to	
Records, The law requir cate has been s	Completed	Disease	a		utopsy findings available completion of cause of es 2 No
n of Vital Records, the Physiciae: The law require After this certificate has been si funeral director, page 2 should t	To Be	examiner? 1 Yes 2 No  Hospital: 1 Inpatient 2 FR/Outpatient 3 DOA  Other4  27. Manner of Death  28a. Date of Injury  28b. Time of Injury  28c. Injury at W.		Residence 6 Other	r:
Division of Vital Records, P.O. Box 68760, within 24 hours after death.  To the Hospital or Attending Physiciae: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans	Certification:	1 Natural 2 X Accident 3 Suicide 4 Homicide Homicide 1 Natural 5 Pending Investigation 6 Could not be determined (Specify) Public Park	subje	ct exposed to on (Street and Number or Ru yn, State) 200 Dels nersburg, Md.	ural Route Number City
To the Hosp within 24 hou To the Fune completely fi	edical C	29a. Certifier (Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death and manner stated.	d place, and due to the	cause(s) and manner as stat	red.
F SF S	W	29b. Signature and title of certifier  29c. License numb  O.C.M.E.	ber	29d. Date signed (Mo	
		30. Name and address of person who completed cause of death (Item 23a)  Russell Alexander MD. Assistant Medical Examiner 900 W. Baltimore Street	et, Baltimore, MD	21223	
S1 Regis	tate	31. Date filed (Month, Day, Year) 32. Registrar's Signature	CME		

Buhrman Kenneth		rd For State	St	ate of	Maryla	and / Di	epartii Certific	ate of	Death	and	Wiente			g. No			
Physicia		gistrar Decedent's Nam	e (First, Midd	le,Last)								1	Date of Deat Month	Day Y	'ear	3. Time of 1	
Medical Examin	er	R	uhrman	Ke	nneth	Bai	rd				110000		January 19	9, 2011 4c. Count	ty of Deat		
	4	a. Facility Name (	if not institution	n, give s	treet and nu	ımber)		4	b. City, Tov		ocation of	Death		St. Ma			
		24400 Men				7 Age (In	yrs. last bi	rthday)	If Under		If Under	24Hrs. 8	8. Date of Birl	h(MM/DD/YY	YY) 9, Bi	irthplace (Sta	te or
Funeral Director	5	Social Security N		6. Sex		7. Age (III			Months	Days	Hours	Min.	Septembe	er 9, 192	3 Fore	ign <b>Virgi</b> country)	.n1a
Director	_	228 - 16- Isual Residence		1 A N	1 2 F			87 Yrs				<u></u>				Talled	e City Limits
any		0a. State	10b. County			10c	. City, Tow	n or Locati	ion							1	s 2 X No
<b>.</b>	5	Maryland	St	. Ma	ry's						11ywc	ood		0g. Citizen of	What Co		
arylar Sa-f s		10e. Street and Nu							10f. Zip C	code				og. Cilizen of		unity?	
the M		24	4350 01	Ld Ho	ollywo	od Ro	ad	1		20	)636	in2 / Snec	cify Yes or No	- 14. Ra	USA ace - Ame	erican Indian,	Black,
eath with the Maryland items 23a or 28a-f show ust be notified at once.	Funeral	11. Marital Status 1 X Never Marr	ried 2 N		12. Was De Armed F	orces?		13. Wa	es, specify	Cuban,	Mexican,	Puerto Ri	ican, etc.)		/hite, etc.		
or ite	킲	3 Widowed			1 X Yes	2	No	1	Yes 2	No	specify:			Specia	44.17	nite	
rs afte	<u>a</u>	15. Decedent's E					ted) 16a	a. Deceder	nt's Usual O	ccupatio	on (Give k	ind of wo	rk done d)	16b. Kind of	Busines	s/Industry	
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5-0 iled w Hygie d other		17. Father's Name	e (First, Middle			Doine	1			- I			Mert	al Bur	ehan	1	
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than	o Be	19a. Informant's N	lame/Relation	nship (Ty	arion pe, Print )	Daile	<u>-</u> T	19b. Mailin	g Address	(Street	and Num	ber or Ru	ıral Route Nu	mber, City or	Town, Sta	ate, Zip Code	)
Imore, MD 21215-0036  Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Heath and Montal Hygiene.  tant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once	F		e Jame			riend			15248	Poi	nt Loc	kout	Road, S	aint Ini	goes,	MD 2068 or Town, Star	84
e, N I and 3 Health item		20a. Method of D			Pomoval	from State		e of Dispo natory or o	sition (Nam ther place)	e of cem	netery,		Date ary 21,				
Baltimore, semit. Pages I a Department of He Important: If ite		4 Donation	5 Other	Specify:		monn oran	Metr	opoli	an Cre	mato	ry	2	011			ia, Virg	
Baltimo permit. Pages Department o Important: injury or oth		21. Signature of F	uneral Service	ce Licens	se <del>o</del>			22.	Name and	Address	of Facility	Matti P.O.	ingley-C Box 270	ardiner , Leona	rdtow	n, MD 20	650
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	ner	if eny, leading to cause. Enter Un	immediate		Due to (or as	s a consequ	uence of):										
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f, P.O. Baires that the designed by the	ğ	Part II. Other si	giiiicant con	Idiaono	COMMISSION	9 (0 4		•					1 □ Y	es 2 🗸 No			
LS, F quires en sign													24a. Wa	is an	24b. Were	e autopsy find r to completion	dings available of cause of
cords, law requir has been s	Completed												per	formed?	deat	th? Yes	2 No
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Division tal or Attendi us after death. ral Director: A	Įį.	3 Suicide	6 🗌 (	Could not	t be 28e. F				treet, factor	y, office	bullaing, i	etc.	- Tour	, State) vell Dean Ro			
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Division of Vital F To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director. After this certifi	51	Z3a. Ceruner 4	CertifyIn	g Physic Examine	er: On the ba	isis of exam	knowledge nination an	d/or invest	igation, in n	ny opinio	on, death	occurred	at the time, da	ato un = p. = - ,			(s)
To th	Medical	29b. Signature			and mann	ner stated.					nse numbe			29d. Dat	te signed	(Month, Day	, Year)
		Lu	UTZ							0.0	C.M.E.			Janua	ıry 20, 2	2011	
VP		30. Name and	address of pe	rson who	completed	cause of de	eath (Item :	23a)					D 04000				
3 kmg		Ana Rub		Assista	ant Medic	al Exam	iner 9	00 W. B	altimore	Street	t, Baltim	nore, M	D 21223				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 22 Day Year 2011 8:40 Henry Peter Baumgartner Ам January Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death St. Mary's Hospital St. Mary's Leonardtown 5. Social Security Numbe If Under 1 Year If Under 24 Hrs. . Age (In vrs. last birthday 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** (Month, Day, Year) July 14, 1930 Country) Ohio 1 **₹** M 2 □ F Hours Min Director 284-24-7664 80 Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Lexington Park 1 Yes 2 X No Maryland St. Mary's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20653 USA 46005 East Sunrise Drive 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 Specify: White and Mental Hygiene. is marked other than "natural", 1 Yes 2 No Specify Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business Industry United States (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Government **Budget Analyst** other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked of any injury or other traumatic eve any injury or other traumatic eve ည Mabel Price Henry Peter Baumgartner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara May Baumgartner/ Wife 46005 East Sunrise Drive Lexington Park, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Januar yate 29, 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Leonardtown, Maryland Charles Memorial Gardens 2011 Signature of Funeral Service Licenses 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270 Leonardtown, Maryland 20650 23a. Part 1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ard, 9 disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequent of) Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical レ*Mga*/ れぐり ガなツ Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death 4 ☐ Pregnant s been signed by the 1 ☐ Yes 2 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an certificate has b irector, page 2 sl autopsy performe 1 Tes 2 No Division of Vital 25. Was case referred to medical examiner? æ 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 XN0 1 🗌 Yes 욘 1 Inpatient 2 ER/Outpatient 3 I DOA After this 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 1 Natural 5 Pending work Accident Suicide 1 Yes 2 No Investigation within 24 hours after death To the Funeral Director: / completed filled in by the 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 60

Registrar

DHMH 17 Rev 7/2009

State

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32. Régistrar's Signature

20650

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JAN 25 2011

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death January 20, 2011 Physician/ 6:12 a.M. William Lerov Buckler Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's Hollywood 24130 Hollywood Road If Under 1 Year If Under 24 Hrs g, Birthplace (State or Foreign 8. Date of Birth 7. Age (In vrs. last birthday) Social Security Number **Funeral** 1 X M 2 □ F Months Davs Hours (Month, Day, Year) Country)
Maryland Director 215-36-4183 71 Usual Residence of Decedent f show 10d, Inside City Limits 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director ral", or items 23a or 28a-f s Examiner must be notified 1 Yes 2 X No Maryland St. Mary's **Hollywood** 10f. Zip Code 10a. Citizen of What Country? Funeral 24130 Hollywood Road 20636 United States "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. 1 ☐ Yes 2 🕅 No If Yes, Give 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify Specify: 3 Widowed 4 Divorced White Year or Dates event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Public Works Painter 11 permit. Page 1 and 2 should be filed wi Department of Health and Mental Hygic Important: If item 27 is marked other any injury or other traumatic event, # Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) ပ Howard Theodore Buckler, Sr. Mary Agnes Wood 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rose Marie Buckler/Wife Hollywood Road, Hollywood, MD 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Charles Memorial Cem 01/25/2011 Leonardtown, MD 4 ☐ Donation 5 ☐ Other (Specify) Edward N. Brinsfield, 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 20650 22955 Hollywood Road, Leonardtown, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death AUURO Physician/ disease or condition Medical resulting in death) Due to (or as a onsequence of) **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a conse uence of) or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last physician a the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 5 Other (specify) Pregnant at time of death 2 No been signed by the should be detached 9 Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 □ No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has be irector, page 2 s autopsy performed? 1 ☐ Yes 2 🚺 No 2 🗆 No 1 Tes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 2 💢 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA ပ 4 Nursing Home 5 X Residence 6 Other (Specify) To the Hospital or ...... within 24 hours after death.
To the Funeral Director. After thi 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: 1 Natural 2 Accident injury work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifi 14285 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar Boyd II,

William D.

M.D.

32. Rec

25365 Point Lookout Road, Leonardtown,

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ 2011 January Mary Virginia Banton 6:35 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's Leonardtown St. Mary's Hospital 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Davs Hours Min. (Month, Day, Year) 2/30/1930 Country) Virginia 1 □ M 2 🗓 F Director 80 223-34-7310 Usual Residence of Decedent or 28a-f shov 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at Director 1 Yes 2 X No Maryland St. Mary's Drayden 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral United States 46455 Hyatt Court 20630 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No Yes, specify Cuban, Mexican, Puerto Rican, etc.) þ 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: 3 X Widowed 4 □ Divorced White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. I other than " Elementary/Seconday (0-12) College (1-4 or 5+) Retail Sales 12 Auditor Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental F permit. Page 1 and 2 should be fi Department of Health and Mental Important: If item 27 is marked any injury or other traumatic ev once. ည Edna Mack Fielder Frederick Roy Wade 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 46455 Hyatt Court, Drayden, MD 20630 Linda Sue Ball/Daughter Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Brinsfield-Echols Cre 01/25/2011 | Charlotte Hall, MD 4 Donation 5 Other (Specify) Sonature of Baneral Service Lice Edward N. Brin 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Brinsfiela, M00052 22955 Hollywood Road, Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cong Physician/ ytone near disease or condition Medical resulting in death) Due for as a consequence of): Examiner Securitizity list noncitions if any, leading to immediate cause. Enter Underlying Examine cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last executed Due to (or as a consequence of): Physician/Medical or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day 5 Other (specify) 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> 1 🗌 Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? this certificate 2 No 25. Was case referred to medical director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No Certificate: To 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at completed filled in by the funeral 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After work? iniury 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Hospital Medical 29a. Certifier Exertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0604 25 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mehrdao 31. Date filed (Month, Day, Registrar's Signature 32 State Registrar

DHMH 17 Rev 7/2009

VIRGINIA

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 State Registrar Certificate of Death 2. Date of Death . Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ January 26, 201Ĭ 9:31 a.m. Breslauer Matilda Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** St. Mary's Piney Point 45080 Lighthouse Road 8. Date of Birth g. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Funeral Hours Mary Land Days Min (Month, Day, Year) 2/16/1922 1 M 2 X F Director 88 577-26-8694 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location Director 1 Yes 2 No Piney Point Maryland St. Mary's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 20674 45080 Lighthouse Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14 Race - American Indian. Black, White, etc. Yes 2 No Yes, Give Completed by 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 X No 3 X Widowed 4 ☐ Divorced White Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Anna D'Ambrosio Nicholas Puchetti 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 45080 Lighthouse Road, Piney Point, MD Susan Ross/Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date ☐ Burial 2 X Cremation 3 ☐ Removal from State Brinsfield-Echols Cre 01/28/2011 | Charlotte Hall, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Signature of Funeral Service Licensee Shawn Aylesworth Hollywood Road, Leonardtown, MD 20650 M01521 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final concer Physician disease or condition resulting in death) Medical Due to (or as a consequence of) 2 months Examiner Sequentially list conditions, Examiner Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Physician: The law requires that the death certificate be executed and use as the burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? for Pregnant at time of death sate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy certificate has death? 1 Yes 2, No Yes director, p 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ျ To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir this 28b. Time of 28c. Injury at work? 27. Manner of Death 28a. Date of injury 28d. Describe how injury occurred Certificate: (Month, Day, Year) injury 1 Natural 5 Pending 1 Yes 2 No Investigation 6 Could not be Accident Location (Street and Number or Rural Route Number, City or Town, State) Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) Registrar's Signatu State JAN 28 2011 anto Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3 Time of Death Day 3:19P M 2011 25, Bishoff Jan. Robert Claude 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Garrett Co. Mem. Hospital Garrett Oakland 8. Date of Birth (Month, Day, Year) 12/24/1919 If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number Age (In yrs. last birthday, 6. Sex Days 1 XM 2 ☐ F Maryland 91 212-14-3148 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 XNo Friendsville Garrett MD 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 21531 U.S.A. 3868 Friendsville Road 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 X Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 XNo Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 1 2 College (1-4or 5+) Truck Driver Dairy 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Hobart Bishoff Martha Alice 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) P.O. Box 250, Oakland, Harold White/ P.R. MD 21550 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition Hoyes oundred rplace) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/29/11 Friendsville, MD Methodist Cem. 22. Name and Address of Facility Newman Funeral Homes P.A. 21. Signature of Funeral Service Licensee 26722 Garrett Hwy., McHenry, MD 21541 23a. Part1. Enter the disease, or complications that dused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of death. Immediate Cause (Final disease or condition resulting in death) AthERoschotic Cardiovascular difeat 455 Due to (or as a consequence of): 4/8 TYPERTENIUM Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): YRS iabetes mellitars Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9□ Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

**Physician** /Medical Examiner

**Physician** 

/Medical

Director

Funeral

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**Examiner** 

**Funeral** 

Director

show r 28a-f show notified at

r than "natural", or Items 23a or the Midical Examiner must be

Department of Health and Mental Hygiene important: If item 27 is marked other than any injury or other traumatic event, the Ma

death with the Maryland

filed within 72 hours after

Pages 1 and 2 should be

Baltimore, Maryland 21215-0036

Examiner burial-trar attending physician for use as the buria Physician/Medical ed by the a ş Completed filled in by the funeral director, Be P after death. Medical Certification: within 24 hours af

To the Funeral D

completely filled i

The law requires that the death certificate be executed

To the Hospital or Attending Physician:

Division or Vital Records, P.O. Box 68760,

9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. Was an autopsy performed 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital:

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

1 Yes 25 No 2 ER/Outpatient 3 DOA 1 🔲 Inpatient 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

and title of certifier 29b. Signature

29c. License number D30035 29d. Date signed (Month, Day, Year)

1 ☐ Yes 2 ☐ No

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NALD RICHARMS (OZZ MEMPRIAL PRINC JAK CANO MD 21550

Registrar

31. Date filed (Month

27. Manner of Death

Natural 2 Accident

3 ☐ Suicide

29a, Certifier

4 ☐ Homicide



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January 20, 2011 11:10P. M Gertrude S. Becker Medical 4b. City, Town, or Location of Death Rockville 4a. Facility Name (if not institution, give street and number) County of Death Montgomery Examiner Hebrew Home of Greater Washington Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 321-16-9133 1 □ M 2 👿 F Months Days Hours April <sup>D</sup>16, 1922 Iffinois 88 Yrs. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho Director "natural", or items 23a or 28a-f s edical Examiner must be notified Rockville Maryland Montgomery 1 Yes 2 No 10g. Citizen of What Country? United States 10e, Street and Number 10f. Zip Code 6060 California Circle, #102 20852 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: Specify: 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) marked other than matic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) private Dancer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Samuel Simmons Sofia Harris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6060 Califronia Circle, #102 Rockville, MD 20852 Charles Jeffrey Becker -son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite 14 Burial 2 ☐ Cremation 3 ☐ Removal from State Judean Mem. Gardens 1/23/2011 Olney, Maryland injury ( 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses any ir Bonara do Vice Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** ORGANISMS Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of): attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical certificate be Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No the Hospital or Attending Physician: The law requires that the death Month Day Year ed by the g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by certificate has been sign irector, page 2 should be 1 ☐ Yes 2 🔊 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 🗌 No Yes 2 No 1 🗌 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 XNo Other: မ 1 Inpatient 2 ER/Outpatient 3 IDOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 1 Natural 28d. Describe how injury occurred Certificate: 5 Pending 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 □ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 2011

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DHMH 17 Rev 7/2009

Registrar

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MONTRUSE

30. Name and address of person who completed cause of death (Item 2da) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1 Decedent's Name (First Middle, Last) 2. Date of Death 3. Time of Death 2<u>011</u> Physician/ Jan 22 0450 Byrne Medical Jean 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegany Cumberland WMHS-RMC If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6, Sex 7. Age (In vrs. last birthday) Funeral 1 M 2 F Hours Min. Month, Day, Ye Nov 29 Country) MD Director 212-32-8123 75 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits should be filed within 72 hours after death with the Maryland Director "natural", or items 23a or 28a-f s idical Examiner must be notified Cumberland 1 Xes 2 No MD Allegany 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21502 USA 10301 Christie Road NE 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 XIVo
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black White etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: 3 ☐ Widowed 4 ☐ Divorced white Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical E 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) homemaker <u>own home</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Myrtle (Gordon) Weltman Lawrence Weltman 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD 21502 13711 Bedford Road NE Cumberland Sondra Cave cousin 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Oxemation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/22/201 Scarpelli Funeral Home, P.A. MD Cresaptown 21. Signature of Funeral Service 22. Name and Address of Facility
Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause onleach line. 23a, Part 1 Approximate Interval Between Ons and Death each line. Immediate Cause (Final Priysician disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) physician s the burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Pregnant at time of death Unknown signed by the a Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy page performed? Yes 2. No 2 🔲 No 1 Yes 25. Was case referred to medica director, 26. Place of Death (Check only one) Be examiner? Hospita Other: 2 DNo ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural To the Hospital or Attending within 24 hours after death.

To the Funeral Director; Afte completed filled in by the fun 5 Pending 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title Date signed (Month, Day, Year) Doo 33280 Jan 22, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar GUPTA

31. Date filed (Month, Day, Year)

625 KENT AVENUE CLIMBERLAND MD 21502

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** : 23M 2011 01 17 CHESTNUT **JOSEPH EDWARD** /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner University Baltimore 1108011 BALTIMORE If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 76. Sex 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, **Funeral** Year) Days 1 ☑ M 2 ☐ F 16 1962 MARYLAND APRIL Director 578-94-6996 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10a. State 10b. County Y☐Yes 2 No Director DISTRICT HEIGHTS PRINCE GEORGE'S 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number a or USA 20747 1814 GLENDORA DRIVE 7 is marked other than "natural", or items 23a traumatic event, the Medical Examiner must Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 Never Married 2 Married BLACK Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 72 (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) PRIVATE 10TH LABORER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) h and Mental F GROSS MARY JOSEPH CHESTNUT ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1814 GLENDORA DRIVE DISTRICT HEIGHYS, MARYLAND 20747 MARY CHESTNUT/MOTHER permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other tra of Health 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 □XBurial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify) WASHINGTON NAT'L CEM 1/24/2011 SUITLAND, MARYLAND 21. Signal, e of Funeral, ervir Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 ie, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death 23a Part4 shock, or heart failure. Immediate Cause (Final Squamous Cell CA -**Physician** ral disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner e 10515 Sequentially list conditions, if any local high control cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of: burial-transit be executed hrombo Due to (or as a consequence of) P.O. Box 68760. physician Physician/Medical the as IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) ed by the a detached f 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 | Yes 2 | No 3 | Probably 4 | Months own page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2 No 1□ Yes Division or Vital funeral director 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Hospital or Attending P 24 hours after death. Funeral Director: After t Certification: After 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) completely within 24 and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 8 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sheet horles Baltmore 31. Date filed (Month, Day, Year)

JAN 2 1 2011 State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 12 201<sup>Yea</sup> January 0920  $A^M$ Zandra Campbell Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Silver Spring Holy Cross Hospital Montgomery | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Aug. | 1, 1944 Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 X F 579-56-4455 66 Yrs. **Director** Aug. DC Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland must be notified at Director 1 X Yes 2 No Washington DC 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a United States 900 G Street NE #226 20002 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian "natural", or iter edical Examiner Black, White, etc. 1 Never Married 2 N Married <u>۾</u> Yes 2 No Maryland 21215-0036 African 1 ☐ Yes 2 No Specify. 3 Divorced 4 Divorced Completed American Year or Dates the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene, life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Food Service Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F Bessie Eagle Robert Louis Flournoy ige 1 and 2 should be nt of Health and Men Et item 27 is marke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Cod Washington, DC 20002 315 Franklin Street NE # B2 Teunga Watson - Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗆 Burial 2 🖾 Cremation 3 🗀 Removal from State January 19. permit. Page Department o Important: If any injury or injury or 4 ☐ Donation 5 ☐ Other (Specify) Lee's Crematory Clinton, Maryland 2011 21. Signature of Funeral Service Livens 22. Name and Address of Facility Stewart Funeral Home, 4001 Benning Road NE 20019 Washington, DC 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ <u>Acute Renal Failure</u> disease or condition Medical resulting in death) Du Enle ephatopathy Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last Cardiomyopathy and burial-tran Due to (or as a consequence of): attending physician I for use as the buria Physician/Medical certificate be Pneumonia Box 68760 IF FEMALE: 23c. If ves, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Live Birth 2 Fetal death requires that the death in the past 12 months?

1 Yes 2 No Month Veal Day 5 Other (specify) Pregnant at time of death the g Unknown P.O. þ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an aw has autopsy page 2 performe Hospital or Attending Physician: The certificate Yes 2 X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 X No ပ 1 🔀 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After Natural 5 Pending work' 1 Tyes 2 🗌 No ☐ Accident within 24 hours after death

To the Funeral Director: / Investigation 3 Suicide Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

Kanwaljit Kaur Nagi,

IAN 1 9 2011

31. Date filed (Month, Day, Year)

MD

32, Registrar's Signature

1500 Forest Glen Road Silver Spring, Maryland

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 22, 2011 8:45AM January Mabel Love CHAMBLIN 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Washington Williamsport Homewood Nursing Home If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year Days Virginia 1 □ M 2 🖾 F 97 31 1913 Jan. 215-34-3904 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 2X No Hagerstown Maryland Washington 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21740 U.S.A. 10837 Allen Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 ∐Yes 2 No If Yes, Give Yeer or Dates: 1 Never Married 2 Married white 1 ☐ Yes 2 No Specify: 3₺ Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) education teaching 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Gertrude Peacock Fenton Mercer Love, II 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17321 Ontario Drive, Hagerstown, Maryland Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) January 28 2011 Hillsboro, Virginia Hillsboro Cemetery 22. Name and Address of Facility Minnich Funeral Home 415 East Wilson Blvd., Hagerstown, Maryland 21740 Due to (or as a consequence of) Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 △

Examiner The law requires that the death certificate be executed P.O. Box 68760, Division of Vital Records, To the Hospital or Attending Physician: The law requir within 24 hours after death.

To the Funeral Director: After this certificate has been si completely filled in by the funeral director, page 2 should I

burial-transit

attending physician for use as the burial

signed by the a

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

28a-f show

? Is marked other than "natural", or items 23a or 28a-f sho traumatic event, in the decided at trauminer must be notified at

72 hours after

Baltimore, Maryland 21215-0036

Funeral

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Completed

Be

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permit. Pages 1 and 2 should be flie Department of Health and Mental Hy Important; If Item 27 Is marked oth any Injury or other traumatic event 19a. Informant's Name/Relationship (Type. Print) Susan Chamblin - daughter 20a. Method of Disposition 1 I Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Kalille 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory prest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 Completed 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Y Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 1 Medical Examiner: On the basis of examination and/or investigation in my onlines, death assured at the cause(s) and manner as stated. 29a. Certifier Medical timer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical Ex and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signatu

State Registrar 30. Name and address

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2:10 AM Downs Cavanaugh Medical Tan 2011 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 8241 Kavanglen Lane Washington <u>Fairplay</u> Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth Funeral 9. Birthplace (State or Foreign 1 XM 2 □ F Days Months Country) Maryland July 23, 1937 218-38-1882 Director 73 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Direct 1 Yes 2 XNo Maryland Washington Fairplay 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? the Medical Examiner must be Funeral 23a 8241 Kavanglen Lane 21733 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 XNo Black, White, etc. ò 1 Never Married 2 Married \$ Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: "natural", If Yes, Give Specify 3 Divorced 4 Divorced Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d Mental Hygiene. marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) 12 Farmer Agriculture Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Charles Earl Cavanaugh Elizabeth 1 and 2 should b of Health and Mer item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gloria Cavanaugh - Wife 8241 Kavanglen Lane Fairplay, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 s
Department of H
Important; If ite
any injury or ot
once. 1 ▼ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Greenlawn Mem. Park Jan. 26,2011 Williamsport,Maryland 21. Si per e o Fune de los Licensee Osborne Tuneral Home, P.A. 425 S. Conococheague St.Williamsport,MD 21795 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician, Medical resulting in death) Due to (or as a consequence of) Examiner awantially list conditions Sequentially liet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tran that initiated events resulting in death) Last Due to (or as a consequence of). ing physician are as the burial. Physician/Medical P.O. Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Vear Pregnant at time of death the 9 Unknown signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 □ Probably 4 □ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performe certificate Yes 2 Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 XNO ျ 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify this funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funeral Natura! 5 Pending 1 🗌 Yes 2 🗆 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 20a Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MI 31. Date filed (Month, Day, Year) 2011 egistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 21, 2011 Marvin Carr, Sr. January William 9:04 p. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 26436 Anne Court St. Mary's Mechanicsville 5. Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 🔯 M 2 🗆 F Months Hours Country) Maryland 0270871935 **Director** 217-30-2208 Usual Residence of Decedent 3a or 28a-f show t be notified at 10h County 10a. State 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Directo 1 🗌 Yes 2 😾 No Mechanicsville Maryland St. Mary's 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ns 23a c Funeral 26436 Anne Court 20659 USA r than "natural", or items the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. 1 Never Married 2XXMarried Completed by Yes 2 XXNo Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give 3 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 1 and 2 should be filed within 72 if Health and Mental Hygiene. item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) NAF Maintenance Foreman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 William Ρ. Carr Aletha Wynn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other ti Cathy L. Carr/Spouse 26436 Anne Ct., Mechanicsville, MD 20659 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Charles Memorial Grd 01/27/2011 Leonardtown, MD 21. Sign ture of Funeral Service Licenses 22. Name and Address of Facility Brinsfield-Echols Funeral Home, P.A. P.O. Box 128, Charlotte Hall, MD 20622 29a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween Immediate Cause (Final RESPIRATION! Onset and Death Physician disease or condition Medical resulting in death) **Examiner** YESTRI. PULMONALE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami Princovary GIRANIC ノモラン Cause (Disease or iinjury that initiated events USCTNULTIVE sician and burial-trans Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown 9 Unknown ed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed t 23e. Did tobacco use contribute to the cause of death? Completed by DIABLIES MELLITUS Division of Vital Records, Physician; The law requires 1 Yes 2 No 3 Probably 4 Unknown MIMOR TENGON 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an performed? Yes 2 No filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) ၉ 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: After t 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 Natural injury 5 Pending work?
1 Yes 2 No s after death. 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined 24 hours a Funeral L Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the 1 only one) 29b. Signature and title of certi-29d. Date signed (Month, Day, Year) MID 056096 1-25-11

(i) db

State Registrar Rajbinder S. Gill, 31. Date filed (Month, Day, Year)

, M.D. 24035 Three Notch Rd., Hollywood, MD 20636

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JAN 2 6 2011 Server S. Sanature

Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, within 24 hours a To the Funeral I

🕍 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) R+3 Box 3221 Keyser, WV 26726 Saweikis M.i Authory 31. Date filed (Month, Day, Year)
JAN 2 4 2011 32. Registrar's Signature

State Registrar

0688 neth Camiel DeB 1	ruycker State of Maryland / Department of Hea For State	Ith and Mental Hygiene	2011 03135						
Physician/	egistrar . Decedent's Name (First, Middle,Last)	2. Date of Death	3. Time of Death						
1		Town, or Location of Death	4c. County of Death Montgomery						
Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Ur Mor	der 1 Year   If Under 24Hrs.   8. Date of Birth (	(MM/DD/YYYY) 9. Birthplace (State or Foreign Country)						
	073-60-4255	APR 8,	1961 New York  10d. Inside City Limits						
•	Maryland Montgomery Potomac	ip Code 10g	1 Yes 2 X No						
h the Mary 3a or 28a outified at	8175 Inverness Ridge Rd.	20854	Jnited States  14 Race - American Indian, Black,						
rr death with the Maryland or items 23a or 28a-f sh must he notified at one Funeral Director	1 X Never Married 2 Married Armed Forces? If Yes, specific Yes 2 X No	dent of Hispanic Origin? (Specify Yes or No- cify Cuban, Mexican, Puerto Rican, etc.)	White, etc.  Specify: White						
Safte safte	or Dates:  15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usu	2 X No specify: al Occupation (Give kind of work done orking life. DO NOT use retired)	6b. Kind of Business/Industry						
5-0036 ed within 72 hour tygiene. the Medical Exan Completed		s Manager	Telecommunication/MCI						
MD 21215-0036 d 2 should be filed within 7 th and Mental Hygiene. m 27 is marked other than annatic event, the Medies To Be Comple	Camiel A. DeBruycker	Noreen A. MacKer	nzie						
MD 21 nd 2 should alth and Mer m 27 is man summatic ev		ncerport Rd., Spence							
Baltimore, bernit. Pages I an Department of He Important: If ite injury or other tr	1 Burial 2 X Cremation 3 Removal from State Atlantic Crematory 2/1/2011 Glen Burnie								
Balti permit. Departm Imports injury o	21. Signature of Funeral Service Licensee Thiba Thiba M00956 7 Par 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the modern than 23b. Part I. Enter the disease, or complications that caused the death. Do not enter the modern than 25b. Part I. Enter the disease, or complications that caused the death.	nd Address of Facility deau Mortuary Service k Ave., Gaithersburg,	, p.a. MD 20877						
/Medical	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the moderal failure. List only one cause on each line. Immediate Cause (Final disease a. Tramadol and Amitript		st, shock, or heart Approximate Interval Between Onset and Death						
Examiner	or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions.  b.								
ed nisit Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):  Due to (or as a consequence of):								
execut an and al - tra	33 27 28a-f per me g912 2-14-11 vt								
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be exwithin 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial ledical Certification: To Be Completed by Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 5 Other (S		23d. Date of delivery Month Day Year						
P.O. Be that the de med by the detached f by Phy	Part II. Other significant conditions contributing to death but not resulting in the underly	ang caace given in the	pacco use contribute to the cause of death?  2 ✓ No 3 Probably 4 Unknown						
of Vital Records, P.O. og Physician: The law requires that it.  The law requires that that this certificate has been signed by the conneral director, page 2 should be detactor. To Be Completed by F.		24a. Was al autops perform 1 🗸 Yes 2	prior to completion of cause of death?						
Vital Reconsistent National Processis of the Constitution of the C	25. Was case referred to medical examiner?  1 ✓ Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatient 3	26.Place of Death (Check only one)  DOA Other Nursing Home 5 F	Residence 6 🗹 Other: Scene						
on of Viral or of Viral or of Viral or or or or or or or or or or or or or	27. Manner of Death  1 Natural  5 Pending  28a. Date of Injury (Month, Day, Year)  28b. Time of Injury (Month, Day, Year)  7 Panding  6 1-25-11  7 Pending		ow injury occurred ingested drugs						
Division o spital or Attending tours after death. neral Director: After filled in by the fune Certification:	Accident Investigation  3 X Suicide 6 Could not be determined (Specify) Tesidence	ory, office building, etc. 28f. Location (S or Town, St <b>Potomac</b>	treet and Number or Rural Route Number, City ate) 8175 Inverness Ridge, Montgomery Co, Md.						
Division of Vital I  To the Bospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certificantlelety filled in by the funeral director.  Medical Certification: To Be (	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at one) 2 Medical Examiner: On the basis of examination and/or investigation, in	the time, date and place, and due to the cause	e(s) and manner as stated.						
NAC NEW TO SERVICE OF THE PROPERTY OF THE PROP	and manner stated.  29b. Signature and title of certifier	29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year) January 26, 2011						
	30. Name and address of person who completed cause of death (Item 23a)  Laron Locke MD. Assistant Medical Examiner 900 W. Baltim	ore Street, Baltimore, MD 21223							
State Registral	20 Bogistoria Cignatura	Ž.							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 9:59 Januar 201 Tony Steven Dattilio Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Washington County Meritus Medical Center Hagerstown If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign . Social Security Number 8 Date of Birth 7. Age (In yrs. last birthday) Funeral S. Birthplace (State Country) Maryland Days Min (Month, Day, 1 💢 M 2 🗆 F 220-28-3808 May Director 77 Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director Maryland Washington County 1 🗌 Yes 2 🔯 No Hagerstown o 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 11517 Dellwyn Dr. 21740 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. or) Completed by 1 Never Married 2 X Married 1 X Yes 2 No If Yes, Give 5 Year or Dates.5 1 ☐ Yes 2 💢 No Specify: Specify: White "natural", 3 🗆 Widowed 4 🗆 Divorced permit. Page 1 and 2 should be filed within 72 hours Department of health and Mental Hyglene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Door Mfg. Company Electrician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Nicola Dattilio Rosa Prospero Dattilio 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Natalie Dattilio-wife 11517 Dellwyn Dr. Hagerstown, MD 21740 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rest Haven Cemetery 1-24-2011 Hagerstown, MD 21 Signature of Funeral Service Licenses 22. Name and Address of Facility Douglas A. Fiery Funeral Home Eastern Blvd. North Hagerstown. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Cardio Physician/ Dylyoug disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Pregnant at time of death 1 ☐ Yes ∠ ☐ 9 ☐ Unknown the 9 | Linknown s been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No page 2 certificate has 1 Yes 2 No Be 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) examiner? 2 No Hospital Other: 1 Yes ပ္ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death. **To the Funeral Director:** Al completed filled in by the fu 1 Yes 2 No Accident Investigation Suicide 6 Could not be 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William Mc dos al (gung b) SH 9+1 54 11110 31. Date filed (Month, Day, Year) State

Registrar DHMH 17 Rev 7/2009 JAN23

Baltimore, Maryland 21215-0036

Box 68760

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 7:35 Pм 2011 Bernice Amanda Joy Dean January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's 44233 Greenery Lane Hollywood Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral (Month, Day, Year) April 6, 1910 1 □ M 2 🖾 F Months Days Hours Maryland 100 Yrs Director 15-46-4842 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location death with the Maryland at Director notified 1 🗆 Yes 2 ី No Hollywood Maryland St. Mary's 10f Zin Code 10g. Citizen of What Country? ö 10e Street and Number Examiner must be Funeral 23a 44233 Greenery Lane 20636 items 2 12 Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Bace - American Indian 11. Marital Status Armed Forces? Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 0 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 72 hours after 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: "natural", 3 X Widowed 4 □ Divorced Completed White the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working if Health and Mental Hygiene. item 27 is marked other than other traumatic event, the Me life DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Greenhouse / Retail 12 Owner Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ပ be William Gwinn Joy Mary Blanch Heard and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Dale Lee Dean, Jr. / Grandson 44243 Greenery Lane, Hollywood, MD 20636 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) January 26 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Hollywood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Chapel Cemetery 2011 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270, Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions Examiner Due to (or as a o if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events The law requires that the death certificate be executed burial-transit and resulting in death) Last physician s the burial Physician/Medical Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregrant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 mor Month Day Year Pregnant at time of death signed by the a Id be detached f 2 No Unknown 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy page performed certificate 1 Yes 2 No 2 Yes Division of Vital Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital 2 No Other: 1 Yes 욘 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Deal 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate; injury 1 Natural 2 Accident 5 Pending work 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

24035 Three Notch Road, Hollywood, MD 20636

Patil,

Α.

Adinath

31. Date filed (Month, Day, Year)

MD

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Dorothy Jane Dillon January 2011 6:46 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** St. Mary's Hospital Leonardtown St. Mary's 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, March 9 Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Hours 1929 Washington. Director 579-32-8291 81 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No Maryland St. Mary's Mechanicsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 30160 Curtiss Road 20659 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14 Race - American Indian If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 2 X No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Yes 1 Yes 2 X No Specify: If Yes, Give White 3X☐ Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker At Home Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ٥ James R. Garner Lola Sherwood 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret Squires/Daughter 30160 Curtiss Rd., Mechanicsville, MD 20659 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 💢 Cremation 3 ☐ Removal from State 27-2011 4 ☐ Donation 5 ☐ Other (Specify) Brinsfield-Echols Crem. Charlotte Hall, MD 22. Name and Address of Facility Brinsfield-Echols F.H., P.A., 30195 Three Notch Rd., Charlotte Hall, MD 20622 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Kespiratery disease or condition Medical resulting in death) Due to (or as a consuluence, of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) attending physician and for use as the burial-tran that initiated events resulting in death) Last Completed by Physician/Medical or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Day Year Pregnant at time of death signed by the 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an this certificate has performed 2 🗌 No Yes 2 No 1 Yes 25. Was case referred to medica examiner? æ 26. Place of Death (Check only one) Hospital 2 **V** No Other: ု့ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After (Month, Day, Year) 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 0604 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20650 May 1) MD eo ner 31. Date filed (Month, Day, Year) State JAN 2 6 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
RegistraMFND#23e,24a/boerMD,1/25/11;BW,McQCertificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 9:07 рм Hazel Katherine Edwards 2011 January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Washington Adventist Hospital Park, Maryland Takoma 7. Age (In yrs. last birthday) If Under If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Social Security Number Funeral (Month, Day, Days 1 □ M 2 🗓 F Months Min. Yrs. Director 159-28-5971 Pennsylvania Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 X Yes 2 No MD Prince Georges Upper Marlboro 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 12707 Conwood Court 20772 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Administrative Assistant Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Isaac Wayns Laura Waters 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frank L. Edwards - Son 2707 Conwood Court, Upper Marlboro, MD 20772 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State 1 🖾 Burial 2 🗆 Cremation 3 🗔 Removal from State Cedar Hill Cemetery: 1/25/2011 4 ☐ Donation 5 ☐ Other (Specify) Suitland, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Murray Funeral Home, 4804 Ga., Ave., NW, Wash, DQ 23a. Part 1. Enter the disease, or complications that caused he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Physician Acute MUOCARDIAL INFARCTION Medical resulting in death) Due to (or as a consequence of) Examiner CORONARY Gequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending nhwalant completed filled in by the funeral director, page 2 should have also a completed filled in by the funeral director, page 2 should have also a completed filled in by the funeral director, page 2 should have also a completed filled in by the funeral director, page 2 should have a completed filled in by the funeral director, page 2 should have a completed filled in by the funeral director, page 2 should have a completed filled in by the funeral director, page 2 should have a completed filled in by the funeral director, page 2 should have a completed filled in by the funeral director. Due to (or as a consequence of): Physician/Medical IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) Day Yes 2 X No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by KENAL FAILURE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown HYPERTHUSION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 1 Yes 2 X No To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 A No Other: 1 Inpatient 2 DER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated re and title of certifie D40324 address of person who completed cause of death (Item 23a) (Type, Print) THROMA PARK MARYLAND 7600 CARRELL AVENUE, FACEP TERRY JODPLE mo, 31. Date filed (Month, Day, Year) State Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene

Janica Wane I		1- For State Registrar  State of Maryland / Department of Health and Mental R  Certificate of Death	Re	2011 eg. No.	U3141
Physic Medical Exan		1. Decedent's Name (First, Middle,Last) Danica Marie Elliott	2. Date of Deat Month January 2		3. Time of Death 0955 hrs
Same?		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Dea		4c. County of Daa	
- 1		Doctors Community Hospital Lanham	[0.00]	Prince Georg	
Funera Directo		5. Social Security Number 20-31-8094 6. Sex 17. Age (In yrs. last birthday) If Under 1 Year If Under 24H Months Days Hours Mi		1974 Fore	irthplace (State or ign outling ryland
		Usual Residence of Decedent  10a State 10b. County 10c. City, Town or Location			10d. Inside City Limits
faryland	5	Maryland Prince George's Greenbelt			1 X Yes 2 No
the Mary	ä	10e. Street and Number 24D Crescent Road 10f. Zip Code 20770	10	og. Citizen of What Co United St	
hours after death with the Maryland "natural", or items 23a or 28a-f she Examiner must be notified at once	Funeral	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No No Specify:		White, etc.	rican Indian, Black,
ours aft	P P	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of		Specify: N 16b. Kind of Business	hite Undustry
0:36 rithin 72 ho ene er than "na dedical Ex	Completed	Elementary/Secondary (0-12)  College (1-4 or 5+)  College (1-4 or 5+)  None	etired)	none	
b, MD 21215-0036 and 2 should be filed within 72 hours a teath and Mental Hygiene from 27 is marked other than "natura	Be Co	Robert Charles Kenny Diane M	ne (First, Middle, M Marie Mil	.ech	
MD 2 d 2 should lth and M n 27 is m	٩	19a. Informant's Name/Relationship (Type, Print)  Diane Marie Teetes -mother  19b. Mailing Address (Street and Number or 2205 Shore Drive Edge	Rural Route Num	ber, City or Town, Stat Naryland 21	e, Zip Code) .037
re, MC s I and 2 si of Health ar of free 27		20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City o	
a it it it		4 Donation 5 Other Specify: Metropolitan Crematory 1/2			, Virginia
Baltir permit. F Departme Importation		21. Signature of Funeral Service Licensee  22. Name and Address of Facility and 4400 Powder Mill R	lt Funera Road Belt	l Home, PA sville, Ma	ryland20705
Physiciar /Medica		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac failure. List only one cause on each line.	or respiratory arre	st, shock, or heart	Approximate Interval Between Onset and
xamine		Immediate Cause (Final disease or condition resulting in death)  a. Atenolol Poisoning  Due to (or as a consequence of):			Death
	_	Sequentially list conditions, b.			
	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Ullease or highly that illiated			
ited d ansit	Exa	events resulting in death) Last  Due to (or as a consequence of):  d.			
e execucian an	Medical	x UNPENDED 23a,27,28a-1 per me g913 3-9	-11 vt		10 30
760, icate by physicate but the but	/Mec	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the		23d. Date of deliver	,
Box 68760, e death certificate be executed the attending physician and ed for use as the burial - transit	Physician/	past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregn 4 Pregnant at time of death 5 Other (Specify) 9 Unknown	ancy	Month	Day Year
i, P.O. E ires that the d signed by the	Jy P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tob	pacco use contribute to	the cause of death?
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physiciae: The law requires that the death certificate be executed within 24 hours after death.  To the Fuorral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans.	Completed		24a. Was a autops perform 1 ✓ Yes 2	y prior to ned? death?	utopsy findings available completion of cause of es 2 No
tal Recting The certificate ector, page	BeC	25. Was case referred to medical examiner?	Laborat .		
f Vid Physic er this	2			tesidence 6 Othe	r:
on of tending P eath. or: After the funera	tion:	1 Natural 5 Pending (Month, Day, Year) 1 Yes 2 X No			atonolol
Division of Vital tall or Attending Physiciso: 15 after death.  al Director: After this certiled in by the funeral directors	Certification:	2 Accident 3 X Suicide 6 Could not be 6 Could not be	28f. Location (St		ural Route Number, City
Dispital of the sale of the sa	Cert	4 Homicide determined (Specify) residence	24 Cres	cent Rd. G	reenbelt, M
Division  To the Hospital or Attent within 24 hours after death To the Fuoeral Director: completely filled in by the	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and one)			
To 1 With To 1	Med	29b. Signature and title of certifier 29c. License number		29d. Date signed (Mo	
		G// O.C.M.E.		January 21, 201	
-		30. Name and address of person who completed cause of death (Item 23a)			
	tate	Russell Alexander MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltin  31. Date filed (Month, Day Year) 37 Registrar's Signat le	nore, MD 212	23	
S	tate	registral s signature			

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AMEND ITEM#10a,b,c,e,f,perfff,G914,4/19/2011,WS

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January 17, 2011 Year 15:04 P M Merrill L. Fisher Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Clinton Prince George's Southern Maryland Hospital Social Security Number If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year 6. Sex **Funeral** 1 🖾 M 2 🗆 F Days Hours Min. (Month, Day, Year), 1920 Country) DC 90 Nov. Director 579-12-4251 Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Directo Maryland Upper Marlboro Washington 1 X Yes 2 No **DC** P.G. 10f. Zip Code 20772 20011 10e. Street and Number 3603 Eton Drive 10g. Citizen of What Country? Funeral <del>IŽ36 Quincy</del> Street NW United States 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married 1 X Yes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0036 African 1 Yes 2 No Specify Specify: Completed 3 X Widowed 4 Divorced American Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Procurement Officer Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Maude Whipps Louis H. Fisher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh
Derartment of Health ar
Important: If item 27 is
any injury or other trau Angela D.F. Byrd - Daughter 811 Postwick Place Bowie, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 25, January 4 ☐ Donation 5 ☐ Other (Specify) Brentwood, Maryland Lincoln 2011 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Stewart Funeral Home, Inc. 4001 Benning Road NE Washington, DC 20019 23a. Part Finter the disease, o complications that caused the death. o not enlet the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final influenzae Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): merabolic acidosis physician and s the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical CAB6 X2/1964 auter discase Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Day Pregnant at time of death 2 🗌 No ed by the a 9 Unknown 9 Unknown signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Mork 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 → Unknown 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of death? page 1 ☐ Yes 2 ☐ No 1 🗌 Yes 2 🔊 No Division of Vital funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 No 1 🗌 Yes မှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending e Funeral Director: Aft 2 Accident
3 Suicide
4 Homicide Μ Investigation 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) To the Hospital o within 24 hours af To the Funeral D Medical 29a. Certifier 🕻 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

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Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND TITEM#19a, per INF, G912, F10/20 F11, WS

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ESTHER JANUARY 201<sub>1</sub> 8:55P Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 3608 ETON DRIVE UPPER MARLBORO PRINCE GEORGE 5. Social Security Number If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 6. Sex 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Days Hours Min. 1 M 2 X F DETROIT Director Yrs. 579-74-3774 87 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD PRINCE GEORGE UPPER MARLBORO 1X Yes 2 No 6 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be Funeral 3608 ETON DRIVE 20772 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: BLACK Specify Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) HOUSEWIFE PRIVATE 3yrs Be 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မ WILLIAM CALDWELL SR permit, Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic RUTHAL CALDWELL GREEN 19 Informati's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RIDA BROWN/DAUGHTER 3608 ETON DRIVE UPPER MARLBORO, MD 20772 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) HARMONY CEMETERY 1-22-2011 LANDOVER, MD 22. Name and Address of Facility JB JENKINS FUNERAL HOME Signature of Funeral Service Licensee 7474 LANDOVER RD LANDOVER, MD 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Stage Physician/ disease or condition resulting in death) seacs Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) that the death certificate be executed resulting in death) Last Due to (or as a consequence of) sician a burial-Physician/Medical attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ Pregnant at time of death Day 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 No 1 Yes 2 No \_\_ Yes Be 25. Was case referred to medical completed filled in by the funeral director, 26. Place of Death (Check only one) Hospital 2 No 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manne of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural injury work?
1 Yes 2 No 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LIPPMAN MD 705 DIGITAL 31. Date filed (Month, Day, Year 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

of Vital

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
RegistrarAMEND#24aperMD, 1/24/11, BMW, McCo Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Jeffrey Starling Frawley Physician/ Januar y 16, 2011 9:05 A M Medical 4a. Facility Name (if not institution, give street and number)
9401 Turnberry Drive 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Potomac Social Security Number . Age (In yrs. last birthday) Funeral If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign (Month, Day, Year 3/27/1959 1X M 2 □ Washington DC Director 577-74-9112 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director MD Montgomery Potomac 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? United States 10e. Street and Number items 23a or Funeral 20854 9401 Turnberry Drive 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc. or i 1 ☐ Yes 2 XNo If Yes, Give 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. "natural", Specify: 3 Widowed 4 Divorced White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, the Men Elementary/Seconday (0-12) College (1-4 or 5+) Sales and Marketing Internet Be 18. Mother's Name (First, Middle, Maiden Surname)
Dorothy Starling 17. Father's Name (First, Middle, Last) James Maurice Frawley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9401 Turnberry Dr. Potomac, MD 20854 Dorothy Frawley / Mother 20b. Place of Disposition (Name of Potomac Comparatory of the Meth. 20a. Method of Disposition 20c. Location - City or Town, State 1 km Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Church Cemetery Cemetery : 1/20/2011 | Potomac, MD 22. Name and Address of Facility Joseph Gawler's Sons Inc. /20/2011 Signature of Funeral Service Lie 5130 Wisconsin Ave. NW Washington, DC 20016 23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Hypertensive Cardiovascular Disease years Medical Due to (or as a consequence of) Examiner Atrial Fibrillation months Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transit <u>Thyrotoxicosis</u> years and that initiated events Due to (or as a consequence of) resulting in death) Last the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) 2 No detached 9 Unknown 9 Unknown ģ cate has been signed I page 2 should be dete Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 1 Yes 2 No 1 Yes 2X No within 24 hours after death.

To the Funeral Director. After this certifics completed filled in by the funeral director, t Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 | No မ 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 😾 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) DO7147 1/18/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nimetz MD 5530 Wisconsin Ave, Chevy Chase, MD 20815 Allen A. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

JAN 24

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 03:50 AM 201 anuar Medical 4a. Facility Name (if not institution, give street and number, 4c. County of Death 4b. City, Town, or Location of Death Examiner Howar Genera 0/unbe Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex If Under Funeral Social Security Number Age (In vrs. last birthday) Country A . 64 Days Min 8 Mapt 9 7 1 94 6 1 □ M 2 🛣 F 143-36-9085 Director Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10d. Inside City Limits 10a. State 10c. City. Town or Location should be filed within 72 hours after death with the Maryland Director Ellicott City MD Howard 1 🗌 Yes 2 🛚 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral USA 21043 8937 Chapel Avenue 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 A No Specify: White "natural", 3 Widowed 4 A Divorced permit. Page 1 and 2 should be filed within 72 hours Important: In the first and Mental Hygene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Human Resources Director Food Vending Co. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Violet LaRue Kline Carl Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Monica Sause/Daughter 1808 Shore Drive Edgewater, Maryland 21037 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🔀 Removal from State Oakland Cemetery 1/24/2011 Distant, Pennsylvania 4 Donation 5 Other (Specify uneral Service Lio PHITE IT PANDES REPARALDI FUNERAL SERVICE, P.A. Signature 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence Examiner Sequentially list conditions, Examiner cause (Disease or linjury Due to for as a consequence Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-tran and that initiated events Due to (or as a consequence of resulting in death) Last s been signed by the attending physician should be detached for the second Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Day Year Pregnant at time of death 9 Unknown q Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, 1 Tes After this certificate has been Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) ည 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical 🕰 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Mulse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certification 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5005 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 24 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav Year Month Physician/ а м 20 5:40 2011 Helen Jean FOX .Tan Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 16909 Warbler Court Washington Hagerstown
If Under 1 Year I If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth Social Security Number 7. Age (In vrs. last birthday) **Funeral** (Month, Day, Year) Days Hours Min 1 □ M 2 🛛 F Director 78 1931 <u>Pennsylvania</u> 220-26-<u>5893</u> Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director 1 Yes 2X No Maryland Washington Hagerstown 10g. Citizen of What Country? 10e, Street and Number Funeral 16909 Warbler Court 21740 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married d Mental Hygiene. marked other than "natural", or δ Yes Yes, Give 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 👿 No Specify: 3 X Widowed 4 ☐ Divorced Completed White Year or Dates injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15, Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Her own home Be permit. Page 1 and 2 should be filed or Department of Health and Mental Hyy Important: If item 27 is marked oth 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Paul Seilhamer Gertrude Lewis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Donald M. Fox - Son Queen Ann's Court, Hagerstown, Maryland 21740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) /25/2011 Hagerstown, Maryland Hill Cemetery Signature of Funeral Service License 22. Name and Address of Facility Minnich Funeral Home holestos Ε. Wilson Blvd. Hagerstown, Maryland Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
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1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 ☐ Unknown 1 Yes 2 No 24b. Were autopsy findings available 24a, Was an prior to completion of cause of death? autopsy performe 200 No Hospital or Attending Physician: The L 24 hours after death. Funeral Director: After this certificate h 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) completed filled in by the funeral director, Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ပ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending work? 2 🗌 No 1 🗌 Yes 2 Accident
3 Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) To the Hospital or within 24 hours a To the Funeral D Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29d. Date signed (Month. Day, Year) 29b. Signature and title of certifier 29c. License number 2255 3+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MEDICA 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

Box 68760

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Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiené 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 201 ac Love Fuller Drema 4c. County of Death 4b. City, Town, or Location of Death Facility Name (If not institution. give street and number, La Plata Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Hours 1□ M 2 🔀 F 234-66-7854 67 January 24,1943 West Virginia Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State 1 ☐ Yes 2 No Charles Faulkner 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 9870 Vera Place 20632 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 📉 No White Specify: 3K Widowed 4 □ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Excavating/ Elementary/Secondary (0-12) College (1-4or 5+) Project Manager Construction Company 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Terry Jesse Richmond Evelyn Mae Curtis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 20632 Terri Kahouk/Daughter 9870 Vera Place, Faulkner, MD 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland Veterans Cem. 2/1/2011 Cheltenham, Maryland 4 ☐ Donation 5 ☐ Other (Specify) M01458 22 Name and Address of Facility
AREHART-ECHOLS FUNERAL HOME, P.A. 20646 Mary's Ave. La Plata,MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode shock, or heart failure. List only one cause on each line. Approximate Interval Between dying, such as cardiac or respiratory arrest Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Newn oni Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last to (or as a consequence of) Due to (or as a consequence of) IF FEMALE yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? seals 1 🗆 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe ANEM He 1 ☐ Yes 2 ☐ No 2 No 25. Was case referred to medica examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **N**o 1 ☐ Yes 1 Dhpatient 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred 27. Manyler of Death 28a. Date of Injury (Month, Day, Year) 28b Time of 28c. Injury at Work? Natural 2 Accident 5 Pending investigation 1 ☐Yes 2 ☐No 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide

Physician /Medical Examiner and burial-tran Division of Vital Records, P.O. Box 68760,

**Physician** 

/Medical

Examiner

Funeral

Director

28a-f show

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Department of Health a Important: If item 27 is any injury or other tra once.

Saltimore, Maryland 21215-0036

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ate has been signed by the attending physician page 2 should be detached for use as the buriar director, funeral

Physician/Medical

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Completed

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Certification: To

Medical

4 Homicide

31. Date filed (Month)

29b. Signature and the of certifier

29a. Certifier

Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Funeral Director: A filled in by completely within 24

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

0 gistrar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and/nanner stated.

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			for State Registrar	Olalo	or mar	ylaria / D	Cer	tificate of L	Death	a	ioniai i iy	Reg. No.		
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	Physici /Media		Vera M Fergu	son							01	27 2	011	7:25 p <sup>M</sup>
-	Examir	er	4a. Facility Name (If not institution		,			4b. City, Town, or		of Death		4c. Cou	inty of Death	
100			Oakland Nursin  5. Social Security Number	ig & Rehal				0ak1	and If Under	∙94 Hrs	8. Date of Bir	***	Garre	
	Funeral Director		215-36-9237 Usual Residence of Decedent	1 M 2 K F	7. Age (	(In yrs. last birth Y	rs.	Months Days	Hours	Min.	04 0	ay, Year)	Cat	nplace (State or Foreign
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9	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Modicel Example Injury or other traumatic event, the Modicel Example Injury or other traumatic event, the Modicel Example Injury or other traumatic event, the Modicel Example Injury or other traumatic event, the Modicel Example Injury or other traumatic event, the Modicel Example Injury or other traumatic event, the Modicel Example Injury or other traumatic event.	Funeral	11. Marital Status 1 ☐ Never Married 2 ☑ Ma	er in U.S.		/as Decedent of Hi Yes, specify Cuba □Yes 2  No			ecify Yes or No Rican, etc.)					
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Mai	d 2 sh Ith an IT is r traur		19a. Informant's Name/Relation		11-	1		g Address <i>(Street a</i> Ferguson				-		ip Code)
<u>ئ</u>	f Heal		Philip R. Fergu 20a. Method of Disposition	ison, Sr.	-nusp			rerguson ition (Name of atory or other place			Date		on - City or T	Town, State
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<u>S</u>	Attendideath.	cati	Accident invest 3 ☐ Suicide 6 ☐ Could	gation				1.5	/es 2 □					
$\leq$	or Al	ırtifi	4 ☐ Homicide determ	ningd 20e. Plat	e of Injury ding, etc. (	- At home, farr (Specify)	n, stre	et, factory, office			28f. Location ( City or To	Street and Ni wn, State)	umber or Ru	ral Route Number,
_	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifyi	ng Physician: To t	ne best of i	my knowledge,	death	occurred at the tin	ne, date a	nd place.	and due to the	cause(s) an	d manner as	stated.
	the Hos hin 24 h the Fur npletely	edical	(Check only 2 Medical one)	Examiner: On the	basis of ex nner state	xamination and	or inv	estigation, in my or	oinion, de	ath occur	red at the time	date and pla	ce, and due	to the cause(s)
	To th within To th	Me	29b. Signature and title of certifie	er				29c. License	number	1 5	t/	29d. Date si	gned (Month	n, Day, Year)
			1 / L					HO	40/	/	/	1	28	(2)
			30. Name and address of person P. Daniel Mil			. , ,		·	) n 1-1 -	nn d	MD 2151	50		
	Sta	te	31. Date filed (Month, Day, Year,	32.		Signature			Jakla	111 <b>U</b> 9	LID 712;	00		
	Registr		JAN 28	2011	ana.	A. 1	ba	who !						
DH	MH 17 Rev 1/20	001												
						0	HIG.	INAL						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Irene Mabel Flanagan 11:23a M 01 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Dennett Road Manor 0akland Garrett 5. Social Security Number If Under 1 Year If Under 24 Hrs. . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 1 🗆 M 2 🕱 F Months Days Hours Min. 194-14-3182 **Director** Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 0akland 1 X Yes 2 No Garrett 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1113 Mary Drive 21550 USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours afte Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exar 1 ☐ Yes 2 X No Specify. White Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Steve Yohman Anna Belle Brosko 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kerry J. Flanagan 649 Glade Road, Friendsville, MD 21531 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ■ Burial 2 ☐ Cremation 3 ☐ Removal from State Paul Lutheran Cem 1/31/2011 4 ☐ Donation 5 ☐ Other (Specify) Latrobe, PA 21. Signature of Funeral Service License 22. Name and Address of Facility David A. Burdock Funeral Home PA 2nd St, Oakland, MD 21550 23a. Pirt 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ 003 Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examin that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day 5 Other (specify) 4 Pregnant : 9 Unknown Pregnant at time of death signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Physician: The law requires Records, 2 No 3 Probably 4 Unknown Completed 1 Yes certificate has been sirector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy 1 Yes 2 No 25. Was case referred to medical examiner?

1 ☐ Yes No funeral director, Be 26. Place of Death (Check only one) Other: မ 1. Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 Yes Certificate: 28d. Describe how injury occurred Hospital or Attending Natural 5 Pending 2 🗌 No Accident Investigation within 24 hours after death

To the Funeral Director: ,
completed filled in by the : Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D15333 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 7/2009

State

Thomas G. Johnson,

JAN28

31. Date filed (Month, Day, Year)

68760

Box (

**Division of Vital** 

32. Registrar's Signature

M.D., 311 North Fourth St, Suite II, Oakland, MD 21550

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death January 22, 2011 Physician/ 4:45 PM Hubert Asa Friend Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Garrett Grantsville Goodwill Mennonite Home 8. Date of Birth 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number **Funeral** <sup>Year]</sup> 1905 Days Hours July II, 1 X M 2 □ F Maryland Director 220-34-1667 105 Usual Residence of Decedent mit. Page 1 and 2 should be filed within 72 hours after death with the Maryland darment of Health and Mental Hyglene. Assurement of Health and Mental Hyglene. Outlant: If time Z? is an arked other than "natural", or items 23a or 28a-f show outlant: If time Z? is an arked other than "natural" or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Director 1 🗌 Yes 2 🕱 No Friendsville MD Garrett 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral USA 21531 2415 Friendsville Rd. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🕱 No If Yes, Give <u>8</u> Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 X Widowed 4 Divorced White Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Farming Farmer Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Nancy Jane Fazenbaker Asa Beal Friend 1 and 2 should b of Health and Mer item 27 is mark 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 696 Gap Run Rd., Friendsville, MD Vera M. Dunithan/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Page 1 a Department of H Important: If ite any injury or ot 1 X Burial 2 Cremation 3 Removal from State 2011 Friendsville, MD Hoyes United Meth. Cem. Jan. 24, 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Newman Funeral Homes, P.A. 21. Signature of Funeral Service License P.O. Box 275, Grantsville, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (kinal disease or condition resulting in death) ESPIRATOR Physician. Medical Due to (or as a consequence of Examiner NEUMONIF Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exam Cause (Disease or linjury the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 
Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 

Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Other (specify) 9 Unknown Division of Vital Records, P.O. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 s 2 No 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 2 No 1 Tes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury work?
1 Yes 2 No Natural 5 Pending ☐ Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Acertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) January 24, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robin Bissell, 124 Miller St., Grantsville, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 2 4 201 Registrar

DHMH 17 Rev 7/2009

		For State	State of M	laryland		artment <i>rtificate</i>			ind M		giene Reg. No.	7111	13	15
		Registrar  1. Decedent's Name (First, Middle, Last	)			imoure				2. Date of De	ath	UII	3. Time	of Deat
Physici	_	Rosalie Althea Fr								January	y 20,	2011	1:35	A
/Medic Examin	-	4h City Town or Location										ounty of Dea	ath	
		Goodwill Mennonit	e Home			Gran	tsvi	lle			Ga	rrett		
Funeral Director		5. Social Security Number 6. Se 187–42–8139	х ]м 2 <b>ў</b> ] F	ge (In yrs. la C	ast birthday) 8 Yrs.	If Under Months	1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Bird (Month, Da Jan• 16	v. Year)		rthplace (State country) ryland	or Fore
and		Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Lo	cation							10d. Inside	City Lin
is 1 and 2 should be filed within 72 hours after death with the Maryland if health and Mental Hygiene. It health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	tor	MD Garrett		Acci	ident								1 ∑Ye	s 2
h the or 28a e noti	irec	10e. Street and Number		11001		10f. Zip	Code				10g. Citize	en of What C	ountry?	
th wit 23a c	a D	101 Town View Dr.	, Apt. 8				1520				USA			
r dea	Funeral Director	11. Marital Status	12. Was Deceden Armed Forces	?	S. 13.	Was Deced If Yes, spec	ent of Hi ify Cuba	spanic Orig n, Mexican	gin? (Spe , Puerto	ecity Yes or No Rican, etc.)	1	<ol> <li>Race - Am Black, Wh</li> </ol>	erican Indian, ite, etc.	
s afte	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 X If Yes, Give Year or Dates:			1 ☐ Yes 2	No X	Specify:				Specify:		
tural sai Ex		15. Decedent's Edu	ucation	- 17	16a. Dece	dent's Usua	l Occupa	ation			16b. Kin	w. d of Busines	hite s/Industry	
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d oth	Be	17. Father's Name (First, Middle, Last)								(First, Middle,	, Maiden S	Surname)		
ould by Meni	မ	William George Gus		z	T		(2)	Ida				T 01 1	7. 0 ()	
12 sh h and is m raum		19a. Informant's Name/Relationship (7)	ype. Print)		1	•	,			Route Numb	-			
1 and 1 and Healtl em 27 ther t		Carl Kahl/Nephew 20a. Method of Disposition		20b. P	lace of Dispo emetery, cre					Somers			r Town, State	
Pages 1 and of He		1 ☑ Burial 2 ☐ Cremation 3 ☐		e   .	emetery, crei on Cem				n 2	23, 201		•		
artme		4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service License		1 210						man Fu				
permit. Pages 1 and 2 since Department of Health as Important: If Item 27 is any Injury or other trau		1.2.	auma	_						sville		21536		
Physician /Medical Examiner  bhysician and sthe purial-transit	Examiner	23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or eleft failure. List only one cause on a hine.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):										Approxim Interval B Onset an	etween	
ute be nysicia ne bu	dical		d											nate Between Id Death
To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician in by the funeral director, page 2 should be detached for use as it	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 Mono	23c. If yes, outcom 1 □ Live birth 4 □ Pregnant 9 □ Unknown	2 ☐ Fetal at time of de	Ideath 3[	⊒Ectopic pr ⊒ Other (sp		,			2:	3d. Date of d Month	elivery Day	Year
uires that signed b	by	Part II. Other significant conditions of	ontributing to death	but not resu	ulting in the u	inderlying c	ause give	en in Part I					ntribute to the cause of de  3  Probably 4 Ur  D. Were autopsy findings averaged to completion of cause death?  1 Yes 2 No	
w req	lete									24a. Was	an	24b. Were	autopsy finding	gs avail
The la te has	Completed									auto perfe 1□ Yes	psy ormed? 2/2 No	prior to death' 1 □ Ye	o completion of ? es 2 □ No	f cause
lan; rtifica stor, p	Be C	25. Was case referred to medical						26. Place	of Deat	h (Check only				
hysic nis ce I direc	To E	examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ Inpa	tient 2 🗆	ER/Outpatie			4 132110	irsing Ho	me 5 Res	idence 6	□Other (S <sub>i</sub>	pecify)	
To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2		27. Manner of Death  1 Natural 5 □ Pending 2 □ Accident investigation 3 □ Suicide 6 □ Could not be		Day Year)	28b. Time o Injury	М		yat k? Yes 2□	No		how injury occurred			
ital or At irs after d ral Direct led in by	Certification:	4 ☐ Homicide determined	building,	etc. (Specify	v)						wn, State)			umber,
the Hosp in 24 hou the Fune ipletely fil	Medical	29a. Certifier 1 Certifying Phonon (Check only one)		of examina		vestigation	i, in my c	pinion, dea			, date and	place, and d	ue to the caus	
To To con	Ž	29b. Signature and title of certifier	_	0	17	290	_	e number	<i>(</i> - :				nth, Day, Year	
		11000	325	1/			DO	034	123	5/	Janu	ary 2	1, 2011	•

State Registrar

DHMH 17 Rev 1/2001

21536

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

JAN 2 4 2011

Robin Bissell, 124 Miller St., Grantsville, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 22 per fh 9912 2-7-11 yt. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** ROBERT J. FISCHER 9:07A 28,2011 Jan. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Harford Upper Chesapeake Medical Center Bel Air If Under 1 Year | If Under 24 Hrs. 8. Date of Birth

2/27/1958 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Days Hours Months Maryland 1√2 M 2□ F 216-66-7704 52 Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐XNo Director Harford Bel Air MD 10g. Citizen of What Country? 10e. Street and Number 10f Zin Code USA 709 Beretta Way 21015 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 1 ☐Yes 2 ☑ No Specify. White Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Insurance Agent 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Irene J. Dylewski William J. Fischer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21666 ပ 19a. Informant's Name/Relationship (Type. Print) William J. Fischer/Father 1503 Marion Quimby Dr., Stevensville, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 1/31/2011 Delta, PA Salem Cemetery 22. Name and Address of Facility
Harkins Funeral Home, Inc.
600 Main Street P.O. Box 485 Delta, PA. 17314 21. Signature of Funeral Service Licensee · Lal Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failude. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) orgestive Due to (or as a consequence of): Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9 🗆 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a Was an autopsy performe Yes 2 1 □ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Natural Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier The Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated.

ne Hospital or Attending P n 24 hours after death. ne Funeral Director: After t To the I within 2 To the I

> State Registrar

29b. Signature and title of certified

**Funeral** 

Director

2 should be filed within 72 hours after death with the Marylan and Mental Hygtene. Is marked other than "natural", or items 23a or 28a-f show aumatic event, if a Madeal Ezura na to notified at

permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev any injury or other traumatic ev

Physician

/Medical

Examiner

and burial-tran

attending physician

the detached

signed by t t be detach

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certificate

this

After

funeral

completely filled in by the

as the I

for use

P.O. Box 68760

Records,

Vital

Robert Joseph Fischer

0.038/11 0.907 (Ithmore) Maryland 21215-0036

29c. License number

hescypeakeD

29d. Date signed (Month, Day, Year)

11

R

1- For State   Registrer   Registrer   Registrer   Registrer   1. Decedent's Name (First, Middle, Last)   2. Date of Death   Month   Day   Year   January 26, 2011   18   Rose   Marie   Foley   Month   Day   Year   January 26, 2011   18   Rose   Month   Day   Year   January 26, 2011   18   Rose   Month   Day   Year   January 26, 2011   18   Rose   Month   Day   January 26, 2011   18   Rose   Month   Day   Month   Day   Month   Day   Hours   Min.   O4/27/1930   Foreign 10   Foreign	me of Death
ROSE MARIE FOLEY  4a. Facility Name (if not institution, give street and number) 215 Westbranch Circle  5. Social Security Number 207-24-0150 1 M 2 F 80 Yrs.  Wonth Jay Year J 80. City, Town, or Location of Death Northeast  Cecil  Funeral Director  Usual Residence of Decedent 10a. State 10b. County  10c. City, Town or Location  10d. II M 2 F 80 Yrs.  Wonth Jay Year J 80. City, Town, or Location of Death Northeast  4c. County of Death Cecil  16 Sex Foreign TOR COMMON DAY YEAR Min.  18 Jay Hours Min.  18 Jay Hours Min.  04/27/1930 04/27/1930 10d. II M 2 F 80 Yrs.  10d.	800 hrs
215 Westbranch Circle  Northeast  Cecil  Social Security Number 207-24-0150  Usual Residence of Decedent  10a. State  10b. County  Cecil  Northeast  Cecil  Funder 1 Year If Under 24Hrs. B. Date of Birth (MM/DD/YYYY) 9. Birthplace Foreign TOL Cell Months  Northeast  Cecil  10 Under 1 Year If Under 24Hrs. B. Date of Birth (MM/DD/YYYY) 9. Birthplace Foreign TOL Cell Months  10a. State 10b. County  10c. City, Town or Location  10d. II  NORTH HART	
Director  207-24-0150  1 M 2 F 80 Yrs. Months Days Hours Min. 04/27/1930  Foreign To For	1.00
10a. State 10b. County 10c. City, Town or Location 10d. I	· (State or INSTOWN NSYLVANIA
NODEK DAGE	Inside City Limits
10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?  215 WEST BRANCH CIRCLE 21901 UNITED STATES  11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No. 14. Race - American Inc.)	Yes 2 X No
215 WEST BRANCH CIRCLE 21901 UNITED STATES 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No. 14. Race - American Inc.	
	dian, Black,
11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Inc. White, etc. 15. Was Decedent Ever in U.S. 16. Yes, specify Cuban, Mexican, Puerto Rican, etc.) 17. White, etc. 18. Was Decedent Ever in U.S. 19. Was Dece	
3 Widowed 4 Divorced If yes 2 No specify: Specify: WHITE  15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry	
College (1-4 or 5+)	,
15. Decedent's Education (Specify only Ingriest grade Continued)  16. Decedent's Education (Specify only Ingriest grade Continued)  17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Surname)	
THE REPORT OF THE PROPERTY OF	
	iode)
20h Blace of Disposition (Name of compten) Date 20c Location - City or Town	D 21901 State
1 XXBurial 2 Cremation 3 Removal from State crematory or other place)  JANUARY	II VODV
201. Method of Disposition  1 X Burial 2 Cremation 3 Removal from State CALVERTON NATIONAL  201. Name and Address of Facility/CROUCH FUNERAL HOME, P.A.  1 27 SOUTH MAIN STREET NORTH FAST MARYLAN	
1127 SOUTH MAIN STREET, NORTH EAST, MART LAN	ND21901 proximate Interval
failure. List only one cause on each line.	tween Onset and Death
Immediate Cause (Final disease or condition resulting in death)  a Acute pneumonia complicating advanced dementia and myocardial fibrosis  Due to (or as a consequence of):	
Sequentially list conditions, b	
Trainy, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last Due to (or as a consequence of):	
tra la	
Month  AMENDED  AMENDED 23a, pt.II, 27, per me, g916 6-6-11 sm  23d. Date of delivery  23d. Date of delivery  Amonth  Day  Amonth  Day	
23d. Date of delivery  23d. Date of delivery  23d. Date of delivery  23d. Date of delivery  23d. Date of delivery  Month Day	Year
AMENDED 23a, pt. II, 27, per me, g916 6-6-11 Sm    Standard Standa	
23d. Date of delivery  Whom the past 12 months?  1	
Diabetes mellitus hypertension    Yes 2   No 3   Probably	findings available
24a. Was an autopsy performed?  1 Ves 2 No 1 Ves autopsy prior to complete death?	etion of cause of
The state of the s	2
examiner?  1 V Yes 2 No  1 Sea. Date of Injury  28b. Time of Injury  28c. Injury at Work?  28d. Describe how injury occurred	ie
28d. Describe how injury occurred  28d. Date of Injury (Month, Day, Year)  28d. Describe how injury occurred  1 X Natural 5 Pending	
28d. Date of Injury - At home, farm, street, factory, office building, etc.  28f. Location (Street and Number or Rural Rough or Town, State)	ute Number, City
ra a bill 0 29a Certifier	
25. Was case referred to medical examiner?  1	se(s)
29b. Signature and title of certifier	ay, Year)
O.C. M.E. January 28, 2011  30. Name and address of person who completed cause of death (Item 23a)	
Donna M. Vincenti, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223	
State 31. Date filed (Month, Pan Year) 7 2011 32. Pegistrar's Signature 1. Spanning 1. Spa	

DHMH 17 Rev 1/2001 OCME 2006

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ Medical nstitution, give str 4b. City, Town, or Location of Death County of Death **Examiner** 8. Date of Birth 9. Birthplace 7. Age (In yrs. last birthday) (State or Floreign **Funeral** 1 🗆 M 2 🗗 F Days Hours (Month, Day, Country) Director 10a. State 10d. Inside City Limits death with the Maryland oortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho i njury or other traumatic event, the Medical Examiner must be notified at 10c. CitynTown or Location Director 1 Yes 2 No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces' Black, White, etc 2 No þ 1 Never Married 2 Married Yes Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes. Give if Health and Mental Hygiene. Item 27 is marked other than "natural", 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ Informant's Name/Relationship (Type, Print) Mailing Address (Stre oute Number, City or Town, State, Zip Co 20a. Method of Disposition 20b. Place of Dispositi (Name of Department of H Important: If ite any injury or ot 1 Burial 2 Tremation 3 Removal from State cemetery, cremat-4 Donation 5 Other (Specify) 21. Signature of Juneral Service Lices 23a. Part 1. Enter the gisease or complications that shock, or heart failure. List only one cause on Immediate Cause (Final complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, proximate Interval Between Onset and Death ach line Physician/ disease or condition resulting in death) monTH Medical Due to (or as a convequence of) **Examiner** Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence on the attending physician and hed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) signed by the a Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform certificate 1 Yes 2 No Yes within 24 hours after death.

To the Funeral Director: After this certifical completed filled in by the funeral director, I 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? ပ ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 1 Inpatient 2 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 3 🗀 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title 29d. Date signed (Month, Day, Year) 30. Name and address of person, who completed cause of death (Item 23a) (Type,

State

Registrar

31. Date filed (Month, Day, Year)

JAN 1 9 2011

32. Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

State
Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ 21°, 2011 January 11:19 p M Goldsmith Marsha Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Charles Hughesville 6033 Goode Road If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth Birthplace (State or Foreign Country) . Age (In yrs. last birthday Funeral (Month, Day, Year) 10/22/1947 1 □ M 2 🛣 F 63 Maryland Director 219-46-6238 Usual Residence of Decedent 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State Director 1 🗆 Yes 2 🙀 No Hughesville Maryland Charles 10g. Citizen of What Country? 10e. Street and Number and Mental Hygiene. is marked other than "natural", or items 23a or raumatic event, the Medical Examiner must be Funeral USA 20637 6033 Goode Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces Black, White, etc. þ 1 Never Married 2 X Married ☐ Yes 2 🗵 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: Specify: If Yes, Give White Completed 3 Widowed 4 Divorced Year or Dates 16a Decedent's Usual Occupation 16b. Kind of Business Industry 15 Decedent's Education (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Banking Teller 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Dalton Doris Fred Alvey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) P.O. Box 627, Hughesville, MD 20637 Earl Goldsmith/Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a Method of Disposition 1 🗌 Burial 2 🖾 Cremation 3 🗍 Removal from State 4 Donation 5 Other (Specify) Brinsfield-Echols 01/24/2011 Charlotte Hall, MD 21. Signature Funcial Service Licenses 22. Name and Address of Facility
Brinsfield-Echols Funeral Home, P.A.
30195 Three Notch Rd., Charlotte Hall Edward N. Brinsfield MD 20622 M00052 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the milde of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one of RICENSON and Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of). the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or imjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year Day Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? 24 hours after death.

Funeral Director: After this certificate has beted filled in by the funeral director, page 2 s performe 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 🔀 Residence 6 🗌 Other (Specify) 1 Yes 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier tigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Medical Examiner: On the basis of examination and/or inve (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I 29b. Signature and title of certifier ned (Month. 1 led (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Catherine Gibson 5:50 January a. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Callaway St. Mary's Hospice House of St. Mary's Social Security Number 6. Sex 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 □ M 2**XX**F Days Hours Min. 04/07/1935 **Director** 214-34-6804 75 Maryland Usual Residence of Decedent 28a-f shov 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland trrent of Health and Mental Hygiene. Hatt; If item 22 is marked other than "natural", or items 23a or 28a-f sho that; If item 27 is marked other than "natural", or items 23a or 28a-f sho itury or or other traumatic event, the Medical Examiner must be notified at jury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County Director 1 ☐ Yes 2X No Maryland St. Mary's Leonardtown 10e. Street and Number 10g. Citizen of What Country? Funeral 23295 Hollywood Road 20650 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2X No Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: 3 ₩ Widowed 4 □ Divorced White Year or Dates 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Board of Education Secretary Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Catherine Coates R. Woodley Goddard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Box 469, Leonardtown, MD 20650 P.0. Carolyn M. Bakewell/Niece Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Department of h Important: If ite any injury or ot 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 02/07/2011 | Cheltenham, MD Maryland Veterans Edward N. Brinsfield, Jr. 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 22955 Hollywood Rd., Leonardtown, MD 20650 M00052 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line nterval Between Onset and Death Immediate Cause (Final Ph\_sician/ Colorany disease or condition resulting in death) Due to (or as a con e uence of): Medical Examiner Sequentially list conditions Examiner Due to or as a consequence of cause. Enter Underlying Cause (Disease or iinjury use as the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of) nding physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate bevet hours after death. 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) g Unknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Division of Vital Records, 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsv perform 2 🗌 No this certificate 1 🗌 Yes Yes 25. Was case referred to medical examiner? Hospice funeral director, 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 K Other (Specify) House 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: To 1 Yes 28c. Injury at work?
1 ☐ Yes 2 ☐ No Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural injury 5 Pending Within 24 hours after death.

To the Funeral Director: Aft Investigation Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basic of examination and/or investigation in my colors. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b, Signature and title of certifie 4 RMS 30. Name and address of son who completed cause of death (Item 23a) (Type, Print) 40900 Merchants La., Leonardtown, MD 20650 Jennifer Schmidt, D.O. State JAN 28 2011

DHMH 17 Rev 7/2009

Registrar

## Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

for State

	1	State Registrar					Cer	tificate of	Death			Reg. No	.20		12	157
Physician	,	1. Decedent's Name (First, Middle	, Last	t)							2. Date of De	D	21/	Vear	3. Time of	
Medica	ıl.		_	ne E.		S					Januar	y 13	3°, 20	1 Year	15:55	5 P M
Examine	r	4a. Facility Name (if not institution						4b. City, Town,				40	c. County		_	
		Southern						If the day of Van	Clin				Pri		George	
Funeral Director		5. Social Security Number  214-56-0008  Usual Residence of Decedent	6. Se 1 [	x 24 м 2 □ F	7. Age (I	n yrs. last b	Yrs.	If Under 1 Yea Months Days			8. Date of Bir (Month, Da Sept • 2		1952	9. Birth Cour	place (State faryla	nd nd
nd how at	눍	10a. State 10b. County			1	0c. City, To	wn or Loc	cation						T.	10d. Inside (	City Limits
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th the Maryland 3a or 28a-f show be notified at	ā	10e. Street and Number		Jeorge .	3			10f. Zip Code					itizen of V	Vhat Cou	ntry?	
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s af	ed by	1 ☐ Never Married 2 🛂 Mar 3 ☐ Widowed 4 ☐ Divorced	ried	1 X Yes If Yes, Giv Year or Da	2 □ No ⁄e			Yes 2 N			nicari, etc.)		Blac Specify:	k, White,	lack	
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Heal Heal		Charlene M. Hay  20a. Method of Disposition	es	- wile		20b. Place	of Dispos	sition (Name of	1		Date				own, State	y zana
permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Meone.		1 Burial 2 Cremation 4 Donation 5 Other (S	pecify	)		ceme	tery, crem Ma eran:	atory or other pland aryland s Cemete	erv	01	/26/201	1 <sub>Che</sub>	e1ter	ham,	Mary	1and
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_ +	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	,	Due to	or as a co	onsequeno	e of):	/	1.19	1					Val	ent
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi Madical Certificate: To Re Completed by Dhysician Madical Examples.	rnysician/ine	F FEMALE: 23b. Was decedent pregnant in the past 12 months?	2		Birth 2	pregnancy Fetal deame of death		Ectopic pregna	ncy				23d. Dat	te of deliv	ery Day	Year
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80		On Name and address of person	vho co	ompleted caus	e of deat	h (Item 23a	) (Type, Pi	int)	linto	m [	nc( 1)	175	35	-/		
State		31. Date filed (Month, Day, Year)	10	32. R	egistraris	Signature	Kal	1 1.1.	كليله	11,1	1117	01,				
Registrar		UMIS & O ZULL	1	the same	10.	1	-									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2011 9:25 AM Eleanor Haliburton January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Regional Hospital Laurel Prince Laure (seorge's If Under g. Birthplace (State or Foreign Social Security Number 6. Sex 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** 1 M 2 X F Months Hours Min 73 Yrs. Wash D.C. **Director** 217-36-7847 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is amended other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Prince Georges Bladensburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5999 Emerson Street 20710 AZU 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian Armed Forces?
1 Yes 2 No Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 ould be filed within 72 hours aft d Mental Hygiene. marked other than "natural", If Yes, Give 1 Yes 2 No Specify: Specify: Completed 3 X Widowed 4 Divorced Black Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) 9th Home-maker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 William Fields Edna Gross 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah Smith / Daughter 6803 Furman Parkway, Riverdale, MD 20737 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Page 1 cemetery, crematory or other place, 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 7-57-77 4 Donation 5 Other (Specify) Harmony Memorial Park Landover, MD 22. Name and Address of Facility Strickland Funeral Services, P.A. 21. Signature of Funeral Service License 6500 Allentown Rd., Camp Springs, MD 20748 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician Hypercapnic Respiratory disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Ecquentially flet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to (or as a consequence of): Obesit To the Hospital or Attending Physician: The law requires that the death certificate be executed Morbid -tran and resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death Other (specify) this certificate has been signed by the all director, page 2 should be detached g Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Sepsis 1 Yes 2 No 3 Probably 4 Unknown Completed Failure Renal 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 🕱 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 💢 No 1 Npatient 2 ER/Outpatient 3 DOA ဂ္ within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral is 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 Natural 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D64818 January 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7300 Van Dusen Road

State Registrar Jason Lee-Llacer, MD

31. Date filed (Month, Day, Year)

2070

Laurel Regional Hospital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <sup>Day</sup>20 Physician/ 2011 William . January Harvey Hanks 9:51 a M Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** Dorchester 5834 Castle Haven Road Cambridge If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** Days July 2, 1943 country) De<u>laware</u> Hours 1 🕅 M 2 🗆 F 218-40-6413 Director 67 Usual Residence of Decedent show 10d. Inside City Limits 10a. State 10c. City, Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at death with the Maryland Director MD Dorchester Cambridge 1 🗌 Yes 2 🏻 No 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 5834 Castle Haven Road 21613 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12 Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 X Yes 2 No Black, White, etc. 1 X Never Married 2 Married þ within 72 hours after Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 X No Specify. If Yes, Give Year or Dates. 1968-72 "natural", Completed 3 Divorced 4 Divorced and Mental Hygiene.

is marked other than "natural
aumatic event, the Medical Ex 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) 5+ Elementary/Seconday (0-12) owner fireplace store Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event William Harvey Hanks Katherine Phillips 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Suzanne Dechaene p.r. 5834 Castle Haven Road, Cambridge, MD 21613 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 A Burial 2 Cremation 3 Removal from State Christ Churchyard 1/22/11 4 ☐ Donation 5 ☐ Other (Specify) Cambridge, MD 22. Name and Address of Facility Thomas Funeral Home P.A. Signature of Funeral Service Licensee 700 Locust St., Cambridge, MD 21613 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between nset and Death Immediate Cause (Final ho Physician/ disease or condition Medical resulting in death) Due to (or as a consequenc of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine Due to (or as a consequence of,... Cause (Disease or iinjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE es, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Other (specify) Pregnant at time of death ed by the a 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown Completed been si 24b. Were autopsy findings available prior to completion of cause of death? cate has l autopsy performed? 2 🗆 No certificate 1 Yes Yes 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Hospital: Other: ပ 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending iniury 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certi 29d. Date signed (Month, Day, Year) 13011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

JAN 24

40

32 Registrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Dorothy 20, 2011 Μ. Horner 9:30 p January Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Silver Spring Montgomery 15311 Beaverbrook Court, Apt. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex **Funeral** Country) D.C. Days Hours Nov. Pay, Yar 15 1 □ M 2 😿 F 577-07-0610 95 Director Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10d Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10b. County 10c. City, Town or Location Director 1 🗌 Yes 2 ื No Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? item 27 is marked other than "natural", or items 23a other traumatic event, the Medical Examiner must be Funeral 15311 Beaverbrook Court, Apt. 3K 20906 TISA 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 ☐ Yes 2 No If Yes, Give 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2X No Specify. Specify: White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done ( life. DO NOT use retired) (Specify only highest grade completed) during most of working Elementary/Seconday (0-12) College (1-4 or 5+) 12 Personnel Specialist Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 Lowell McKinley Margaret McClellan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marcia A. Nilson/Daughter 14524 Cutstone Way, Silver Spring, MD 20905 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 a
Department of H
Important: If ite
any injury or otl 1 Burial 2x Cremation 3 Removal from State 21, Jan. Metropolitan Crematory 4 Donation 5 Other (Specify) 2011 Alexandria, VA 21. Signature of Funeral Service License 22. Name and Address of Eachity ins Funeral Home Inc. Silver Spring, 500 University Blvd. W., MD 20901 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, spock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death
2 yrs Immediate Cause (Final Physician Cholangiocarcinoma disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to for as a consection of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months? Month Day Vear Pregnant at time of death 2 🔀 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Anemia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ื Unknown Were autopsy findings available prior to completion of cause of 24a, Was an autopsy performed? Yes 2 No death? 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 🕱 No Hospital ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 K Residence 6 Cther (Specify, Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🔁 Natural injury work? 5 Pending 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year)

Registrar

10

State

30. Name and address of person who completed case

24

31. Date filed (Month, Day, Year)

Charlene Ozanne-Blankfard, MD

MI

of eath (Item 23a) (Type, Print)

Registrar's Signature

D43202

3305 N. Leisure World Blvd., Silver Spring, MD 20906

January 21, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 11-00524 State of Maryland / Department of Health and Mental Hygiene Nicholas Harper 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician/ 0221 hrs January 19, 2011 **Medical Examiner** Nicholas Robert Harper 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Cecil Union Hospital If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year 6. Sex 7. Age (In yrs. last birthday) 216-89-2560 **Funeral** Days 16 Hours Country) Director 11/03/2010 1 M 2 F N/A Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County 1 Yes 2 No 28a-f show Elkton MD Cecil Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Importment: If item 77 is marked other than "natural", or items 23a or 28a-f sho
injury or other traumatic event, the Melical Examiner must be notified at once. 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code IISA 21921 446 Willow Drive 14. Race - American Indian, Black, Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married 2 Yes If Yes, Give Year 1 Yes 2 X No specify: Specify: White 3 Widowed 4 Divorced \$ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) N/A N/A 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jessica Harper Kenneth Fleenor Jr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) MD 21901 207 S. Main St. North East, Kenneth Fleenor Jr./ Father 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Hickory Grove Cemeterly 1/24/2011 Middletown, DE 4 Donation 5 Other Specify 22. Name and Address of Facility
R.T. Foard Funeral Home, 21. Signature of uneral Service Licensee MD 21921 259 E. Main St. Elkton, Approximate Interval 23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line /Medical Death Asphyxia Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of): Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and The law requires that the death certificate be executed Physician/Medical 5 per Ili g912 2-7-11 vt X UNPENDED X AMENDED signed by the attending physician be detached for use as the burial 23a,27,28a-f per me g915 5-2-11 vt Records, P.O. Box 68760, 23d. Date of delivery 23c. If yes, outcome IF FEMALE 23b. Was decedent pregnant in the Month Year 1 Live birth 3 Ectopic pregnancy Day Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Dio tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 5 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available After this certificate has been uneral director have 2 should 24a. Was an prior to completion of cause of autopsy performed' ✓ Yes 2 No 2 No 1 🗸 Yes 26.Place of Death (Check only one) Hospital or Attending Physician: 25. Was case referred to medical Division of Vital Other Nursing Home 5 Residence 6 Other DOA 1 Yes 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury Certification: 1 Natural 1 Yes 2 X No after death.

Director: A in by the fi 5 Pending subject asphyxiated fd 1:19am fd 1-19-11 2 X Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 6 Could not be or Town, State)
446 Willow Dr. determined residence Elkton, Md. within 24 hours a

To the Funeral 1 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie January 19, 2011 O.C.M.E Jass G 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Melissa Brassell, MD 31. Date filed (Month, Day, Year) 32. Fegistrar's Signatur State

Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death January 31ay Physician/ 201<sup>Y</sup>1<sup>ai</sup> Marzia Hasan 18:38 Pm Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Bethesda Suburban Hospital 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. Funeral Hours 1 🗆 M 2🎾 F <sup>Year</sup>1930 040-77-4997 80 India Yrs **Director** Usual Residence of Decedent or 28a-f show notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director 1 Yes 2 No Marvland Montgomery Potomac 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ò "natural", or items 23a or United States 20854 Funeral 9 Potomac Manor Court 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after death 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11 Marital Status Armed Force Black, White, etc. ğ 1 Never Married 2 Married 1 Yes 2 X No Baltimore, Maryland 21215-0036 Asian 1 ☐ Yes 2 X No Specify: Specify: 3 XWidowed 4 ☐ Divorced Completed Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) own home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Taqui Ali Rizvi 2 Zamrud 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
15600 Crimson Sprie Court Silver Spring, MD 20905 19a. Informant's Name/Relationship (Type, Print) Sved Nagvi -nephew 20b. Place of Disposition (Name of cemetery, crematory or other place)

MD National Mem. Park 2/1/2011 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Laurel, Maryland 4 Donation 5 Other (Specify) Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Ma 21. Signature of Funeral Service Licepee en 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Cardiopulmonary Arrest disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Atherosclerotic Cardiovascular Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to for as a consequence on Examin Cause (Disease or iinjury that initiated events resulting in death) Last burial-trar Due to (or as a consequence of): physician s the burial Physician/Medical The law requires that the death certificate be P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month 5 Other (specify) Pregnant at time of death ned by the a detached for Unknown s been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hypertension Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 page 2 s has 1 ☐ Yes 2X No certificate Division of Vital director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No ျ 1 ☐ Inpatient 2 🔀 ER/Outpatient 3 ☐ DOA en, Marzia this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: eral Director: After filled in by the funera or Attending 1 Natural injury 5 Pending hours after death. 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) To the Hospital within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. сотретен only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c. License number D55779 January 31, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) H. Wickramasinghe, M.D. SH 8600 Old Georgetown Road Bethesda, Maryland 20814

State Registrar 31. Date filed (Month, Day, Year) 32.

FEB 0 7 2011



State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Heckert Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Allegany <u>WMHS-RMC</u> Cumberland Birthplace (State or Foreign Country)

PA 6. Sex If Under 1 Year If Under 24 Hrs 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** Days (Month, Day, Ye May 30 1 🗆 M 2 🗆 F Hours Min. Director 209-20-6667 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Examiner must be notified at Director LaVale 1 XYes 2 No MD Allegany 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or Funeral 21502 USA <u>13 North Woodlawn Avenue</u> 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after d Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or i 1 Never Married 2 X Married Completed by 1 ☐ XYes 2 ☐ No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: 3 Widowed 4 Divorced 1948-195D white injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Frostburg State Unvi. Professor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Clara (Plessinger) Heckert Paul K. Heckert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Wife 13 North Woodlawn Ave. LaVale MD 21502 Sara Heckert 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Gremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MD Scarpelli Funeral Home, P.A. Cresaptown 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part J. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burner to the completed filled in by the funeral director, page 2 should be detached for use as the burner to the completed filled in by the funeral director. that initiated events resulting in death) Last Due to (or as a co sequence of): Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed 1 ☐ Yes 2 ☐ No of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 욛 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 1 Natural 28d. Describe how injury occurred 5 Pending work? Division 1 Tes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Datg signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) F 31. Date filed (Month, Day, Year State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelibie Ink. Énsure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 18 .2011 2:15A Raymond L. January Jones Medical 4a. Facility Name (if not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hospital Takom<u>a Park</u> Montgomery 8. Date of Birth (Month, Day, Year) Social Security Number . Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Min. 1 € M 2 □ F Months Hours Director 239-66-0815 1948 Tune Usual Residence of Decedent 28a-f show 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location within 72 hours after death with the Maryland Examiner must be notified at Director 1 X Yes 2 No PG Suitland MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō Funeral items 23a 3348 Curtis Drive #202 20746 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces?

1 Yes 2 No Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc ò <u>\$</u> 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural" Completed 3 Widowed 4 Divorced Black the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "n: any injury or other traumatic event, the Medic once. (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Shields Annie <u>Mae</u> Percy Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3348 Curtis Drive #202 Minnie Jones/sister Suitland, Md. 20746 ce of Disposition (Name of Baltimore. 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Park! 1/22/11 Landover,Md. 22. Name and Address of Facility Hodges & Edwards F.H. 21. Signature f Funeral Service Licensee Silver Hill Rd., Suitland, Md. 20746 3910 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death Ph\_sician/ disease or condition resulting in death) Medical Due to (or as/a consequence of): **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury to (or as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequance of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death g Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by nce 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No 2 W No Yes 25. Was case referred to medical å 26. Place of Death (Check only one) Hospital 2 **N**O Other: ျ 1 🗌 Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred (Month, Day, Year) injury 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number determined building, etc. (Specify) City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

JAN 2 1 2011

30. Name and address of person who completed cause of death (Item 23a) (

rar's Sice ature

29c. License number
0064024

CHININA, M.D

29d. Date signed (Month, Day, Year,

MD 20912

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ DRRAINE 19:30 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death PRINCEGEORGES PRINCE GEORGES CHEVERI HOSPITAL If Under 1 Year If Under 24 Hrs 6. Sex cial Security Number 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Country) NORTH CAROLINA Days 1 🗆 M 2 💢 F Hours Min. **Director** 250-62-4440 71 Usual Residence of Decedent ms 23a or 28a-f shov must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director DC 1 X Yes 2 ☐ No WASHINGTON 10e. Street and Number 10g. Citizen of What Country? Completed by Funeral 1737 A ST. SE 2000 er than "natural", or items the Medical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian Armed Force Black, White, etc. 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: 3 Widowed 4 Divorced BLACK 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working al Hygiene. life, DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) 12th FEDERAL 4423 TRAIN OPERATOR Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fisher is marked of permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked c any injury or other traumatic eve once. မ MACK FULTON KEELS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) VANESSA DAUGHTER A. JOHNSON WASHINGTON DC 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 1/22/2011 4 Donation 5 Other (Specify) WAGHINGTON. ENWOOD CEMETARY 21. Signature of Funeral Service Lig 22. Name and Address of Facility 20011 BIANCHI FUN, SRUC. 814 UPSHORST. NW WASH. DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Immediate Cause (Final Physician/ RESPITORY FAILURE disease or condition Medical resulting in death) Examiner RHEUMETOID ARTHRITIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Exami attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☒ No Month Day signed by the at d be detached for Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Division of Vital Records, CARDIAC ARYTHMIA Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an KECURRENT SEPSIS autopsy perform After this certificate HYPOXEMIA ENCEPHALOPATH 2 🗆 No 1 Yes Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred or Attending To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Afte completed filled in by the fun 1 X Natural 5 Pending (Month, Day, Year) injury 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of ce 29c. License numbe 29d. Date signed (Month, Bay, Year) 0:4273 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6130 LANDOVER KEVATITY MURTHY CHEVERLLY 31. Date filed (Month, Day, Year)

JAN 2 1 2011 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2011 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Deat **Examiner** roftor Anne 8. Date of Birth (Month, Day, Apr 6 If Under 1 Year If Under 24 Hrs Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🛣 F Months 1933 **Director** 578-42-8644 Towa Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland Director 1 Yes 2 No MD Anne Arundel Crofton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21114 USA 2131 Davidsonville Rd. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married 2 🔀 No 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 🔀 No of Health and Mental Hygiene. item 27 is marked other than "natural", other traumatic event, the Medical Exar Completed 3 Widowed 4 X Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Child Care Mentor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Morris Ketchum Jessup Kathryn Jones Jessup Bassett permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20416 Greenfield Rd., Germantown, MD 20876 Carolyn Banks / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 🔀 Cremation 3 🗆 Removal from State Metro Crematory 1/15/2011 Baltimore, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service 11 ensee 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy., Bowie, MD 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury the Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transi that initiated events resulting in death) Last the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav Year 5 Other (specify) 9 Unknown been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy perform 2 🗆 No 1 Tes within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, t 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 X No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending X Natural work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (SpecIfy) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Elknidge Registrar's Signatur State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ KOULEN DOROTHY JANUARY To 5:00 A M 20T1 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 7953 RIGGS RD. #6 PRINCE GEORGES HYATTSVILLE . Social Security Number If Under 24 Hrs. 9. Birthplace (State or Foreign If Under 1 Year 8 Date of Birth **Funeral** 6. Sex 7. Age (In vrs. last birthday) 1 - M 2 F Days Hours 79 T931 GUYANA **Director** 217**-15-**0949 Usual Residence of Decedent sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 28a-f 1 XYes 2 ☐ No MD PRINCE GEORGE'S HYATTSVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funera 7953 RIGGS ROAD #6 20783 USA death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ö 1 Never Married 2 Married þ 72 hours after Baltimore, Maryland 21215-0036 Specify: BLACK 1 ☐ Yes 2X No 3 Widowed 4 Divorced "natural" Completed Year or Dates the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 12TH HOUSEWIFE PRIVATE permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, I Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ SARAH KOULEN UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, PAMELA NEDD/NIECE 7953 RIGGS ROAD #6 HYATTSVILLE, MARYLAND 20783 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State RESURRECTION CEMETERY 1/21/2011 CLINTON, MARYLAND 4 Donation 5 Other (Specify) Signature of Fun / S ice Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final CARDIAC ARRYTHMIA Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner DEHYDRATION Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the Innerial director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Dav Pregnant at time of death 5 Other (specify) 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2X No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an autopsy perform Yes 2 X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 😾 No မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27, Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🖺 Natural iniury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation 6 Could not be ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 E only one 29b. Signature and title certifier 29c. License number 29d. Date signed (Month. Day, Year,

DHMH 17 Rev 7/2009

State

Registrar

arks

OPHNELL CUMBERBATCH 8416 CENTRAL AVE., CAPITOL HEIGHTS, MD 20743

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Month 2011 1:45 Ρ Susie A. King Jan. 18 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Bradford Oaks Nrg & Rehab. Center Clinton If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Days Hours Months 1 □ M 2**X** F **Director** Georgia 455-48-2954 89 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location works th and Mental Hygiene.
7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Macilcal Experiment must be rectified at 1 ☐ Yes 2 No Director MD Prince George's Fort Washington 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3005 Ivy Bridge Road 20744 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ☐Yes 2X No Specify: Black ş 3 ₩ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) School Teacher Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ben Armstrong Lila Blanchard ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) ant of Health a t; If item 27 is y or other trau Eugene Johnson - Executor 3005 Ivy Bridge Road, Fort Washington, MD 20744 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Page:
Department o
Important: If i
any Injury or
once. 1 █ Burial 2 ☐ Cremation 3 ☐ Removal from State Bliss Military 4 ☐ Donation 5 ☐ Other (Specify) 1/25/2011 El Paso, TX 21. Signatule of Fundral Service I 22. Name and Address of Facility J. K. Johnson Funeral Home, P. A. udith 6503 Old Branch Ave., Temple Hills, MD 20748 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease of Injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed ending physician and use as the burial-transit Due to (or as a consequence of) P.O. Box 68760. Physician/Medical attending properties for use as IF FEMALE: ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Year signed by the a 5 Other (specify) 1 □Yes 2 No 9 Dunknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown s peen s 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 24 hours after death.

Funeral Director: After this certificate has to letely filled in by the funeral director, page 2.8 performe 1 ☐Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural
2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hou To the Funer completely file ©n the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number

State

Registrar

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31. Date filed (Month, Day, Year)

William

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

INVNER

1701 Livington Road Cat washington, MA

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. / 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JANUARY 15,2011 MARY A. LADUCA 0820 M Medical 4a. Facility Name (if not institution, give street and number) 4b. Cify, Town, or Location of Death **Examiner** 4c. County of Death MONTGOMERY ROCKVILLE SHADY GROVE ADVENTIST HOSP. If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | (Month, Day, 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral 5. Social Security Number 068 - 14 - 77511 □ M 2 🛣 F Months 88 922 UTAH Director Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director MD. MONTGOMERY ROCKVILLE 1 X Yes 2 No 10e. Street and Number 6 10f. Zip Code 10g. Citizen of What Country? ems 23a or r must be r Funeral 20850 9701-VEIRS DRIVE USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or iter ledical Examiner r 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 X No Black, White, etc. þ 1 Never Married 2 Married should be filed within 72 hours after Specify: WHITE If Yes, Give 1 ☐ Yes 2X No Specify: Completed 3 Widowed 4 X Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) AT HOME YRS HOMEMAKER Be 17. Father's Name (First, Middle, Last)
SAMUEL LIPARI 18. Mother's Name (First, Middle, Maiden Surname)
MARGARET PLAIA ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>.v</u> Health a TERESA ARZT- DAUGHTER 10216 SWEETWOOD AVE., ROCKVILLE, MD. 20850 Page 1 and 2 Important: If item 2 any injury or other once. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 🎇 Cremation 3 ☐ Removal from State METROPOLITAN CREM. 1/15/2011 ALEXANDRIA, VA. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 222 – WISCONSIN AVE., NW HYSONG CO. WASHINGTON 20007 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final ceremovascular accident Pnysician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exam attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Dav Pregnant at time of death 5 Other (specify) signed by the a 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ cate has been signated by page 2 should b 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗌 No 1 Yes Yes To the Hospital or Attending Physician:
—within 24 hours after death.

To the Funeral Director: After this certifical completed filled in by the funeral director, to To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \(\text{\text{\text{Nursing Home}}}\) 1 \(\text{\text{\text{Residence}}}\) 6 \(\text{\text{\text{\text{Other}}}}\) Other (Specify) 2 XNO 1 Mnpatient 2 ER/Outpatient 3 DOA 27. Manner of Death . Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural 5  $\square$  Pending work? 2 🗌 No Investigation 6 Could not be Accident 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one) 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) 70144 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Murray, MD Drive, Rockville, Mary land 20550 9901 Medical Center 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 1 9 2011 Registrar

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21215-0036

Maryland

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 26 a Landreth January 201Ĭ 6:30 p. Billv Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's Leonardtown St. Mary's Nursing Center If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Hours Days (Month, Day, Year) 03/14/1931 1 X M 2 D I . Virginia Director 233-48-8887 West Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2 X No Springfield Virginia Fairfax 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral 22150 6026 Amherst Avenue USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: White 3 K Widowed 4 ☐ Divorced Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Special Agent Treasury Dept Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Rudd Mae Elmer Landreth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6406 Julian St., Springfield, VA 22150 Allison Albert/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🛮 Burial 2 🗆 Cremation 3 🗆 Removal from State Memorial Pk | 02/01/2011 | Fairfax, VA 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 4 ☐ Donation 5 ☐ Other (Specify) Fairfax Memorial Pk 02/01/2011 Signatur Fugeral Service icens

Edward N. Brinsfield, Jr. M00052 22955 Hollywood Rd., Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one caus Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Esquaritally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year 5 Other (specify) Pregnant at time of death 1 Yes 2 9 Unknown the n 9 Unknown been signed by should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has b page 2 sl autopsy performed? Yes 2 A No After this certificate I 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) director, Be examiner? 1 Inpatient 2 ER/Outpatient 3 DOA ည Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural Accident Suicide injury work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation 24 hours after deatr 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. e and title of certifi 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signatu 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

(15) eme

State Registrar 31. Date filed (Month, Day, Year)

JAN 2 8 2011

32. Registrar's

William Boyd, M.D.

32. Figistrar's Signature

25365 Point Lookout Rd., Leonardtown, MD 20650

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Amend# 17,18,1-28-11, per FHDR, Helliff ate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2°0°11 Edna s. LeGendre January 2141 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 4c. County of Death Woodstock Howard 10801 Enfield Drive Apt. 104 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
Trinidad 7. Age (In yrs. last birthday) If Under 8. Date of Birth **Funeral** 577-92-3654 1 □ M 2 🔀 F Hours 2/2/1917 Director Usual Residence of Decedent show. 10a. State 10b. County 10c. City, Town or Location with the Maryland event, the Medical Examiner must be notified at 10d. Inside City Limits Director · 28a-f MD Howard Woodstock 1 Yes 2 X No 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? Funeral items 23a 10801 Enfield Drive 21163 United States permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental hygiene. Important: If item 27 is marked other than "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 XWidowed 4 ☐ Divorced Specify: Black WWII 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Nursing Assistant **Healthcare** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Preddie ပ James Preddie Ann Butler Annie Butler injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tijuana P. Klas-Granddaughter 7105 Forest Creek Way Hanover, MD 21076 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)

Ft. Lincoln Cemetery 1 XBurial 2 Cremation 3 Removal from State 1/28/11 4 Donation 5 Other (Specify) Brentwood, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Harry H. Witzke's Family F.H.Inc any Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Oy et and Deat 1. Physician/ disease or condition PMOMTAMedical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Day Month Year signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been si should l 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has autopsy performe this certificate 2 🗌 No 1 🗌 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 🗌 Yes 2 No မ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 1 Natural 5  $\square$  Pending 1 Tes 2 🗌 No Accident Investigation ector; / Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide Direc determined 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check within 2 To the F 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

egistrar's Signat

Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** BOK KEUM LEE 20a M 2011 anyary /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Pla Cha La Medica Civista Center If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 💢 F Months Days Hours Min. KOREA 81 NONE Director Usual Residence of Decedent 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location or 28a-f show WALDORF Director MD. CHARLES 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4920 WEBFOOT COURT 20601 KOREA permit. Pages 1 and 2 should be filed within 72 hours after death w Department of Health and Mahral Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, Ite in 21 is more reasonable. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ Yo Specify: ۾ Specify: WHITE-ASAIN 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME HOMEMAKER 7 th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be SUK JUN LEE MYUNG SOON JUNG ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4920 WEBFOOT COURT WALDORF, MD. 20601 HYUN S. BACK-SON 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State HERITAGE MEM. CEM. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 2-3-11 WALDORF, MD. 4 ☐ Donation 5 ☐ Other (Specify) M00479 21. Signature of Funeral Service Licensee RAYMOND FUNERAL SERVICE, P.A. PLATA, MARYLAND LA 20646 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause of each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner NEUR 011 f Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine b Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 moviths? 1 ☐ Yes 2 ☐ No 5 Other (specify) signed by the a d be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying gause given in Part I. 23e/Did tobacco use contribute to the cause of death? Division of Vital Records, 2 cate has been si 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ⑤ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy NEUFOM 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referre examiner? director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral c 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 🛂 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29b, Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Chan. Son 31. Date filed (Mont State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ RICHARD MERCER 1618 P™ January 2011 Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** Silver Spring Montgomery Holy Cross Hospital Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months Days Hours Min. Feb. 24. 1 🔀 M 2 🗆 F 57 Director 294-50-3931 Pennsylvania Usual Residence of Decedent or 28a-f show 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits the Medical Examiner must be notified at Montgomery Silver Spring Direct Maryland 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 20904 USA 1511 December Drive #104 death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Was Decedent Even III 0.3.
Armed Forces?

1 ☑ Yes 2 ☐ No
If Yes, Give 1971 —
Year or Dates. 1975 Black, White, etc. þ 1 Never Married 2 Married within 72 hours after Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 X No Specify: "natural", Completed 3 Widowed 4 X Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Ophthalmic Technician Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jess e Delores Bennett Mercer Frances 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6903 Lady Anne Ct., Greenbelt, MD 20770 Adrienne L. Mercer, Ex.Wife 20b. Place of Disposition (Name of cemetery, crematory or other place)
Cheltenham Veterans 20c. Location - City or Town, State 1 K Burial 2 Cremation 3 Removal from State 01/27/2011 Cheltenham, MD 4 Donation 5 Other (Specify) . Signature of Funeral Service L 22. Name and Address of Facility Jordan Funeral Service, Inc. 20019 4001 Benning Rd., NE, Washington, DC 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Return Interval Between Onset and Death Immediate Cause (Final Respiratory Failure Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Encephalopathy Anoxic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Ventricular Fibrillation/Arrest To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Exami ending physician and use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Infarction Myocardia1 Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕱 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 ☐ Yes 2 ☐ No 2 🗶 No Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 X No ဥ 1 X Inpatient 2 ER/Outpatient 3 DOA 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 □ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Muse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D 67589 2011 ICVA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 99

DHMH 17 Rev 7/2009

Registrar

Harold

31. Date filed (Month, Day, Year)

2 0 2011

Lawson, MD

Box 68760

P.O.

Records,

of Vital

Division

Forest Glen Rd., Silver Spring.

MD 20910

1500

32. Registrar's Signature

11-00395 Tilton D. McDona		Stat 1-For State	e <b>or Print in B</b> se of Maryland	l / Depai	rtment		h and Mer		ene	201	100	3174
Physicia		Registrar  1. Decedent's Name (First, Middle,L	ast)		moute	OI DOGIII		2. D	Re ate of Death	g. No.	3. Time o	of Death
Medical Exami		Tilton	Dwight	McDona	1d, 3	Jr.		Ja	ionth anuary 14	Day Year , 2011	0009	hrs
		4a. Facility Name (if not institution,	_	r)			own, or Location	of Death		4c. County of	Death	
		NB Route 301 at Pierce				La Pla		0.01.b. Io	D-4 4 D:-41	Charles	0 Didb1 (0)	
Funeral Director		570 06 6700	Sex 7. A  X M 2 F	ge (In yrs. las		If Under Months Yrs.		ler 24Hrs. 8. S Min. D	ecembe	1970 er 30,	Foreign Was Country) D	ington. C.
Any		Usual Residence of Decedent  10a. State 10b. County		10c. City, 1	Town or Lo	cation					10d. Insid	de City Limits
ke l		District of Col	umbia	1 "		ington					1 <b>X</b> Ye	es 2 No
Maryland 28a-f show d at once.	Director	10e. Street and Number 10f. Zip Code							10	at Country?		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygeine. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatite event, the Medical Examiner must be notified at once.		2847 Gainsville	e Street,	S.E.;A	pt.20	20	020			United	States	
th with	Funeral	11. Marital Status  1 X Never Married 2 Marri	12. Was Deceder Armed Forces				t of Hispanic Ori Cuban, Mexicar			14. Race - White,	American Indian	, Black,
er dea			1 Yes 2	2 X No	1	_	No specify		, ,	Specify:	B1ack	
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72 ho	i i	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. DO NOT						ruse retired)			Parce1	
MD 21215-0036 to 2 should be filed within 7 th and Mental Fyggene. m 27 is marked other than aumatic event, the Medical	E D	8th grade			Warehouse Sorter				Service			
filed v filed v d other		17. Father's Name (First, Middle, La		C					t, Middle, M ctavia	aiden Surname) a <b>Willi</b>	ama	
212'	To Be	Tilton Dwight  19a. Informant's Name/Relationship	McDonald (Type, Print)	, SI.	19b. Mai	ling Address				er, City or Town		27
AD 2 shou 1 and 1 and 1 and 1 and 1		Crystal Yolanda		end)	1		•			nington,		
Featth Health	- 1	20a. Method of Disposition			ace of Disp	oosition (Name other place)		Dat	e	20c. Location - (		
Baltimore, permit. Pages I as Department of He Deportant: If ite		1 Number 2 Cremation 3 4 Donation 5 Other Species		late			emetery	Jan.2	1,2011	Brentwo	od,Mary	Land
alti mit. ] partm porta ury o		21. Sign ture of Funeral Service/Lic	ensee	/					Hort	on Compa		
		Sandaph (	B. Houte							W.;Washi		
Physician		23a. Part I. Enter the disease, or cor failure. List only one cause on		d the death. [	o not ente	er the mode of	dying, such as o	cardiac or resp	oiratory arres	st, shock, or hear	Betwee	mate Interval n Onset and
Examiner	1	Immediate Cause (Final disease or condition resulting in death)	a. Multiple Injuries									Death
	or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions,  b.											
	je l	sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or lightly that initiated events resulting in death) Last Due to (or as a consequence of):										
	ami											
executed an and al - transit	ical Examiner	• •	d	_								
be exe sician a	ğ	UNPENDED	AMENDED									
Box 68760, re death certificate be the attending physic red for use as the burned for us		IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outco	me of pregna		Fetal death	3 Ectoni	c pregnancy		23d. Date of d	lelivery Day	Year
x 66 h certi tendin	is	past 12 months?	4 Pregnant a	t time of deat	, - <u>-</u>	Other (Specif		c pregnancy		I World	Day	1601
Bo re deat	hys	1 Yes 2 No 9 Unknow	9 Unknown									
P.O.	2	Part II. Other significant conditions	s contributing to deal	th but not res	ulting in th	e underlying c	ause given in Pa	art I.	_	acco use contrib		
requir	Completed							49	24a. Was ar		ere autopsy finding	
eco he law ate has	티	*							perform Yes 2	<u>ned</u> ? de	ath? ✓ Yes 2	_
Ertifica	B B	25. Was case referred to medical		· · · · · · · · · · · · · · · · · · ·		26	.Place of Death	(Check only o			•	
Vita	밁	examiner? 1 ✓ Yes 2 No			R/Outpatie	ent 3 DO	A Other <sub>4</sub>	Nursing Hor	me 5 R	esidence 6 🗸	Other: Scene	
Afte funer		27. Manner of Death  1 Natural 5 Pending			28b. Time o FOUND: 0008 hrs		c. Injury at Work	No Driv		w injury occurred into fixed ob		while
Divisior To the Hospital or Attend within 24 hours after death. To the Funeral Director: completely filled in by the	Certification:	2 Accident Investiga 3 Suicide 6 Could no determine	28e. Place of Ir	njury - At hom	ne, farm, st	reet, factory, o	office building, et	tc. 28f. I	Location (St	reet and Number ate) at Pierce Road	or Rural Route N	lumber, City
n 24 hour re Funera			Ician: To the best of m	ny knowledge	, death occ			ace, and due t	o the cause	(s) and manner a	s stated.	
To th within To th	Medical	one) 2 Medical Examin  29b. Signature and title of certifier	and manner stated.		VOI IIIVESU		License number	zurred at trie		29d. Date signed		221)
	=	A. I Ma 11	// ///				O.C.M.E.			January 14,		ial)
	-	Pluming Suthau  30. Name and address of person who	o completed cause of	death (Item ?	3a)							
		Pamela E. Southall, MD	Assistant Med		,	00 W. Balt	imore Street	t, Baltimore	e, MD 212	223		
Sta	ite	31. Date filed (Month, Day, Year)		ar's Signature								
Registr	ar	JAN & U ZUTT KE	aura di.	war	-							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

		4	State of Maryland / Department State of Maryland / Oct			0011 001 -17						
			Registrar  1. Decedent's Name (First, Middle, Last)	ificate of Death	Reg. 2. Date of Death	No. 3, Time of Death						
	Physicia Medic	n/ al	Sylvia Martin			16, 2011 6:03 P. M						
	Examin		4a. Facility Name (if not institution, give street and number)  12615 Thrush Place	4b. City, Town, or Location of Death <b>Upper Marlboro</b>		4c. County of Death Prince Georges						
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 □ M 2 🕱 F 5.4 Yrs.	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day Yea	9. Birthplace (State or Foreign Country) Washington, D. C.						
	Director	ŀ	579-72-4223 1 1 M 2 M 5 54 Yrs. Usual Residence of Decedent		march 27,							
	ryland -f shor	ctor	10a. State 10b. County 10c. City, Town or Local	<sup>ation</sup> <b>Mar1boro</b>		10d. Inside City Limits 1 <b>X</b> Yes 2 □ No						
	the Ma or 28a e notif	Dire	Maryland Prince Georges Upper  10e. Street and Number	10f. Zip Code	10g.	Citizen of What Country?						
	h with h	Funeral Director	12615 Thrush Place	20772		Inited States						
920	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by	Armed Forces? If	as Decedent of Hispanic Origin? (Sp. Yes, specify Cuban, Mexican, Puerto  Yes 2 <b>X</b> No Specify:	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: Black						
15-0	"2 hour "natur edical	Completed	(Specify only highest grade completed) (Give ki	ent's Usual Occupation nd of work done during most of work	ring I	J.S. Department of						
212	iled within 72 Il Hygiene. I other than '		Elementary/Seconday (0-12)   College (1-4 or 5+)	NOT use retired) Assistant	1	Justice						
Maryland 21215-0036	tal Hyg	To Be	17. Father's Name (First, Middle, Last)		ne (First, Middle, Maid	· '						
ıryla	should be file and Mental I 7 is marked c raumatic eve	-	Jack Martin, Jr.  19a. Informant's Name/Relationship (Type, Print) (Husband) 19b. Mailing	I same 1  g Address (Street and Number or Rur								
χ,	id 2 sh salth ar n 27 is er trau					oro,Maryland 20772						
Baltimore,	e = to		4 Donation 5 Other (Specify)	ition (Name of atory or other place)  Park Crematory	24,2011	c. Location - City or Town, State						
Balt	permit. Page Departmer Important any injury once.	a d				Company Morticians, ;;Washington,DC.2001						
· 1	Pnysician/ Medical Examiner	ıer	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Metastatic Carcinoma of Rectum  Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):									
092	death certificate be executed ne attending physician and ed for use as the burial-transit	edical Examine	Cause (Disease or iinjury that initiated events resulting in death) Last  C. Due to (or as a consequence of):  d.									
. Box 68760	death certiff ne attending ed for use a		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 🕱 Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ 4 ☐ Pregnant at time of death 5 ☐	23d. Date of delivery Month Day Year								
s, P.O.	requires that the des been signed by the s should be detached	by	Part II. Other significant conditions contributing to death but not resulting in the ur  Ascites; Swore Diarrhea; Malnutrit	co use contribute to the cause of death?								
Record	The law ate has bage 2	Completed		24b. Were autopsy findings available prior to completion of cause of death?  No 1 □ Yes 2 □ No								
tal	iician: The certificate rector, pag	Be	25. Was case referred to medical examiner?	26. Place of Death (Chec	ck only one)							
n of Vi	iding Physician: 1 th. After this certifics funeral director, p	ate: To	1 ☐ Yes 2 Ma No 1 ☐ Inpatient 2 ☐ ER/Outpatient  27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28c. Injury at work?  M 1  Yes 2  No	ome 5 🔊 Residence 28d. Describe how in	e 6 Other (Specify)  njury occurred						
Division of Vital Records,	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completed filled in by the fu	al Certificate:	2		28f. Location (Street City or Town, St	t and Number or Rural Route Number, tate)						
	Hospi 24 hou Funer eted fill	Medical	29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investi	gation, in my opinion, death occurred a	at the time, date and pl	lace, and due to the cause(s) and manner stated.						
	To the within To the comple	Σ	only one) 3 Certifying Nurse Practioner: To the best of my knowledge, d 29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month, Day, Year)						
0			I heurs um weehall no	D0007660		January 19, 2011						
			30. Name and address of person who completed cause of death (Item 23a) (Type, Proceedings of the Complete Cause of Season (Type, Proceedings of the Complete Cause of Season (Type, Proceedings of the Complete Cause of Season (Type, Proceedings of the Complete Cause of Season (Type, Proceedings of the Complete Cause of Season (Type, Proceedings of the Complete Cause of Season (Type, Proceedings of the Complete Cause of Season (Type, Proceedings of the Complete Cause of Season (Type, Proceedings of the Complete Cause of Season (Type, Proceedings of the Complete Cause of Season (Type, Proceedings of the Complete Cause of Season (Type, Proceedings of the Complete Cause of Season (Type, Proceedings of the Complete Cause of Season (Type, Proceedings of the Complete Cause of Season (Type, Proceedings of the Complete Cause of Season (Type, Proceedings of the Complete Cause of the Complete Cause of Season (Type, Procedure Cause of the Complete Cause of Season (Type, Procedure Cause of the Complete Cause of the Cause		):Hvattsvi	11e,Maryland 20782						
	Sta		31. Date filed (Month, Day, Year)  32. Registrar's Signature		- ,,							
	Registr	ar	JANGUZUII LENNA DO MORRE									

DHMH 17 Rev 7/2009

DHMH 17 Rev 7/2009

Registrar

31. Date filed (Month, Day, Year)

JAN 2 0 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend #23b per physician01 Centificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 201<sup>Year</sup> Sarah Reid Marcey January 10 8:20 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Sanctuary at Holy Cross Burtonsville 7. Age (In yrs. last birthday) Social Security Numbe If Under 1 Year If Under 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** March 13, 1 M 2 X F 93 Days Hours Virginia 231-18-1549 **Director** Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits notified at Director MD Prince George's 1 Yes 2 □ No Laure1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō ed other than "natural", or items 23a or event, the Medical Examiner must be Funeral hours after death with 7409 Old Sandy Spring Rd. 20707 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?
1 ☐ Yes 2 💆 No Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 K No Specify. Specify: White If Yes, Give Completed 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry Washington Lee (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) High School Cashier 6 Be permit. Page 1 and 2 should be filed v Department of Health and Mental Hyg Important: If item 27 is marked othv any injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Unknown Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah Cristaldi-Daughter 7409 Old Sandy Spring Rd. Laurel, MD 20707 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Mt. Olivet Church Cemetery 1/13/11 Arlington, VA 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Murphy FH 4510 Wilson Blvd. Arl., VA moune 22203 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Cotonary ₽hysician/ disease or condition resulting in death) Medical Examiner Due to (or as a co equence of) Sequentially list conditions Examine cause. Enter Underlying Cause (Disease or iinjury Due to lor as a consequence of for use as the burial-transit that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months? Month Year Pregnant at time of death ed by the a detached f 9 Unknown 9 Unknown Division of Vital Records, P.O. signed k Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Tyes Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an or Attending Physician: The law autopsy performed? 1 Nes 2 No director. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Other: 4 Vursing Home 5 Residence 6 Other (Specify) မ ER/Outpatient 3 DOA To the Hospital or Attending Physi within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir 1 Inpatient 2 I this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 000698 1-10-11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Smith Suite 203 - Ballimine Avenue 31. Date filed (Month, Day, Year) 32. Registra 's Signa State JAN 1 9 2011

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registra MEND#8perFH, 1/26/11; BMW, MoCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Jan. 18, 2011 Joseph Ρ. Meadows 1914 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Montgomery General Hospital Olney Montgomery Social Security Number 8. Date of Birth (Mo2th Day, Year) 3 / 25 / 1925 9. Birthplace (State or Foreign 6. Sex . Age (In yrs. last birthday) If Under **Funeral** Days 1 X M 2 D F Hours 432-22-7737 85 Arkansas **Director** Usual Residence of Decedent or 28a-f show 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.
item 27 is marked other than "natural", or items 23a or 28a-f shor other traumatic event, the Medical Examiner must be notified at. 10a. State 10c. City, Town or Location 10d. Inside City Limits Directo MD Montgomery Silver Spring 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 14400 Homecrest Road 20906 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☐ Nd 943

If Yes, Give
Year or Dates. Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 1-☐ Yes 2 XNo Specify: White Specify: Completed 3 X Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Administrator  $5 \pm$ Dept.of Labor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Presley Meadows Willie Rankin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code).

20100 Tindal Springs Pl. Montgomery Village, 19a. Informant's Name/Relationship (Type, Print) Definit. Page 1 and 2 sh Der artment of Health ar Important: If item 27 is any injury or other trau Betty Ann Meadows/daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☒ Removal from State Ft.Smith Nat'l 4 Donation 5 Other (Specify) 1/24/2011 Ft.Smith,Arkansas PHIMIP ADES RINALDI FUNERAL SERVICE, P.A. 21. Signature, Funeral Service Lic 9241 Columbia Blvd.Silver Spring,Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or he in failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause Disease or iinjury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Month Year ed by the a detached f To the Hospital or Attending Physician; The law requires that the P.O. 23e. Did tobacco use contribute to the cause of death? þ HIN, 1 Chel, Ac-Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed 1 Yes 2 No Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 ☑ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this within 24 hours after death.

D to the Funeral Director: After this completed filled in by the funeral to funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending work 2 Accident
3 Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ponce Philip Dr char 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 2011 lanuar /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner **Baltimore City** The Johns Hopkins Hospital If Under 1 Year If Under 24 Hrs.
Months | Davs | Hours | Min. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** Months 1 □ M 2 🗓 🕱 Days 0270371966 Alexandria VA 227 23 8877 44 Yrs Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes ZXXNo VA Director Arlington Arlington 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code 22205 USA 5701 19th St North Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 14. Race - American Indian, 11. Marital Status Black White etc 1 Never Married 2 Married 1 Yes 2 No White Specify: If Yes, Give Year or Dates: δ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Architect Architecture 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Howard Eugene Cochran Gretchen Louise Wrigley ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5701 19th St N, Arlington VA 22205 Jonathan Myers (Husband) 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metropolitan Crematory 01/15/11 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Alexandria VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Advent Funeral & Cremation Services Falls Church VA and Annapolis MD 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that a shock, or heart failure. List only one cause on e Approximate
Interval Between
Onset and Death
DNE LEWIC aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) IPLE MYFLOMA **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Tectopic pregnancy Live birth in the past 12 months?

1 Yes No
9 Unknown Month Day Pregnant at time of death 5 Other (specify) Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ No 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner?
1 Yes Other: 4 \sum Nursing Home Hospital 2 240 Inpatient 3 DOA 2 ER/Outpatient 5 Residence 6 Other (Specify) ပ္ completely filled in by the funeral Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Natural Accident (Month, Day Year) Injury 5 Pending 1 Yes 2 🗌 No investigation hin 24 hours after deatl the Funeral Director; Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide determined 1/2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation in records. Hospital 29a. Certifier (check only Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) 29b. Signature and title of certifier

CH20 State

DHMH 17 Rev 1/2001

Registrar

600 North Wolfe St, Baltimore, MD, 21287

Name and address of person who completed cause of death (Item 23a) (Type, Print)

M, ()

32. Registrar's Signature

ANN LAW FF

JAN 19 2011

31. Date filed (Month

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January 14, 2011 McBride 1:00 A M Tomoe Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Prince George's Collington Episcopal Life Care Mitchellville 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8 Date of Birth Birthplace (State or Foreign Country)
 Tapan Funeral 1 M 2 XF Months Days Japan 577-58-2463 82 Director Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Mitchellville 1 🗌 Yes 2 🌁 No Maryland Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 10450 Lottsford Road 20721 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, the Medical Examiner Armed Forces Black, White, etc. "natural", or 2 1 Never Married 2 Married ☐ Yes 2XX No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No 3 X Widowed 4 □ Divorced Asian Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Federal Government Interpreter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) I and 2 should be file f Health and Mental I item 27 is marked o ဂ္ Unknown Nakamura Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 151 Redland Ave., Rumford, RI 02916 Raymond McBride - Bro.-in-law tem 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of F
Important: If ite
any injury or ott 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 1/28/2011 Arlington Nat. Cem. Arlington, Virginia 4 Donation 5 Other (Specify) 22. Name and Address of Facility George P. 21. Signatur Kalas Funeral Home alux 6160 Oxon Hill Road Oxon Hill, Maryland 20745 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Physician/ **ALZHEIMERS** Medical resulting in death) Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Examine Due to (or as a consequence of): sician and burial-transit Cause (Disease or imjury that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Day Year ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ate has been signed page 2 should be dei þ Cerebrovascular Accident The law requires 2 xxNo 3 ☐ Probably 4 ☐ Unknown Completed 1 Tes Failure to Thrive 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? Yes 2XX N 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director, After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6x Assisted 2 X XNo 욘 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1XXNatural 5 Pending work? 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month. Day. Year, D 43351 1/14/2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ikechi Okwara MD 12200 Annapolis Road #316 Glen Dale, Maryland

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

JAN 19

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Box

P.O.

Records,

of Vital

Division

32. Registrar's Signature

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Funeral	Г	932 Mulberry Av 5. Social Security Number		Age (în yrs. la	ast birthday)	Hagerst If Under 1 Year	If Unde	er 24 Hrs.	8. Date of Birth	1		9. Birtl	hplace (State or F	oreign
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nd 2 sh ealth a m 27 is ertra		Romaine McCabe	(Wife)		932 1	Mulberry	Ave.	Hage	rstown,	MD	217	42		
permit. Page 1 and 2 should be filed within 72 hours after death with the Mavland Department of Health and Mental Hygiene. Important: If tiem Z7 is marked other than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 Durial 2 Cremation		ate C	emetery, cre	osition (Name of matory or other pla			Date				Town, State	
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To the Hospital or Attending Physician: The law requires that the death certificate be ewithin 24 hours after death.  To the Luneral Director: After this certificate has been signed by the attending physicial completed filled in by the funeral director, page 2 should be detached for use as the bur	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcor 1 ☐ Live Birt			Ectopic pregnar	ю					ate of deli		
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To the Hospital or Attending I within 24 hours after death.  To the Funeral Director: After completed filled in by the funer	Medical	29a. Certifier 1 Certifying	Physician: To the best	of my knowl	ledge, death	occured at the tim	e, date an	d place, ar	nd due to the cau	ise(s) a	and mann	er as sta	ted.	
the Ho nin 24 the Fu npleter	Med	only one) / 3 Certifying	xaminer: On the basis of Nurse Practioner: To			death occurred at t	he time, da	ate and place	e, and due to the	cause	(s) and m	anner as	stated.	ner stated.
o Viti		29b. Signature and title of certifier	. 11 /	/		29c. Licen:	se number	3 2		29d. Da	ate signe	d (Month	n, Day, Year)	
to		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)												
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Stat		31. Date filed (Month, Day, Year)	2011 32. legi	strar's Signat	ture.	bank						ř	15 An	742

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January 0700 AM 201 Kenneth Logan Mason Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Meritus Medical Center Hagerstown 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Year) 36 Hours 1 X M 2 🗆 F Months Maryland Yrs **Director** 74 Nov. 214-34-0906 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 X Yes 2 □ No MD Washington Hagerstown 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 51 West Side Ave. 21740 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Armed Force Black, White, etc. 1 Never Married 2 Married Yes 2 X No δ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White 3 🕅 Widowed 4 🗆 Divorced Completed the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me any injury or other traumatic event, the Me gines. Elementary/Seconday (0-12) College (1-4 or 5+) Crane Operator Mechanical Contracting Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ William Russell Mason Helen Agnes Mowen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael A. Mason/Son 929 Hamilton Blvd., Hagerstown, MD 21742 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Durial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Smithsburg Crematory 1/22/2011 Smithsburg, MD Signature of Funeral Service bicensee 22. Name and Address of Facility Rest Haven Funeral Chapel 21742 1601 Pennsylvania Ave., Hagerstown, MD caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complications the shock, or heart failure. List only one cause on Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of: Examiner Sequentially list conditions, it any, reading to immediate cause. Enter Underlying Examine Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of). attending physician Physician/Medical Box 68760 for use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) Year Pregnant at time of death been signed by the sahould be detached Unknown g Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 Yes 2 No 3 Probably 4 hknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 s autopsy performed Yes 2 has certificate 25. Was case referred to medical funeral director. 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No မ 1 Impatient 2 I ER/Outpatient 3 I DOA After this Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural iniury 5 Pending 24 hours after death Funeral Director: A Accident
Suicide Investigation completed filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical 29a. Certifier Ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Jurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one the 29h. Signature and 29d. Date signed (Month, Day, Year) 50362

9H-3

State Registrar 3424

Baistrar's Signature

Name and address of person who completed cause of death (tem 23a) (Type, Print)

nuary 20 2011

IVania Ave. Hagerstown, MD

For State of N  1 - State Registrar	Maryland / Depa Cen	rtment of Hea		, ,	liene leg. No.	03183
1. Decedent's Name (First, Middle, Last)				2. Date of Deat	th	3. Time of Death
Physician/ Medical Hannah Lee Matlock				January	7 ÎÎ, 20ÎÎ	6:15 A M
4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Loc			4c. County of Death	1
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4 □ Donation to □ Oner (Specify)	Memoria	L Gardens	20	11	Frederick,	
21. Signatus of Funeral Service Licensee	Re   95	Name and Address of Sthaven Fu 01 Catocti	ineral So In Mount	ervices ain Hwy	, Skkot Cod . Frederick	y P.A. , MD 21701
23a. Part 1. Enter the disease, or complications that causs shock, or peart failure. List only one cause on each li	ed the death. Do not ente ne.	r the mode of dying, su	uch as cardiac or	respiratory arre	est,	Approximate Interval Between
Immediate Cause (Fi al disease or onditi	Cerebrov	ascula	n Diss	ense		Onset and Death
Medical resulting in death) Due to (or as	s a consequence of):					
Sequentially list conditions, if any, leading to immediate Due to (o. a.	s a consequence of).					
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as						
per logical part of the per lo	s a consequence of):					
ate be exphysician the burier in the burier in the purier		<u></u>				
IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome		(e			23d. Date of deli	very
O X O X O X O X O X O X O X O X O X O X	at time of death 5	Ectopic pregnancy Other (specify)			Month	Day Year
9 Unknown 9 Unkn		nderlying cause given i	in Part !	220 Did tol	pacco use contribute to	the cause of death?
The significant conditions contributing to death	but not resulting in the di	idenying addae given i	THE GILLS.		es 2 No 3 Pr	
Drds.				24a. Was a		opsy findings available
Records, The law require sate has been sipage 2 should the same of				autops perfori	prior to c med? death?	ompletion of cause of
The base of the ba		26. Place	of Death (Check		2 ATNo 1 ∐ Yes	2 2500
Posital: Hospital:	atient 2 ER/Outpatien	t 3 🗆 DOA Other: 4	1 Amursing Hon	ne_5 🗆 Reside	ence 6 Other (Speci	5y)
27. Manner of Death  28a. Date of in (Month, D)  (Month, D)	jury 28b. Time of injury injury	28c. Injury at work?		8d. Describe ho	w injury occurred	
To Los Library 1	njury - At home, farm, stre		2 🗆 No	8f. Location (St.	reet and Number or Run	al Route Number.
Division of Vital Records,  Ital or Attending Physician: The law requires  a street death:  Be a line of Attending Physician: The law requires  a line of Attending Physician: The law requires  a line of Attending Physician: The law requires  a line of Attending Physician: The law requires  b line of Attending Physician: The law requires  condition of Attending Physician: The law requires  condition of Attending Physician: The law requires  a line of Attending Physician: The law requires  condition of Attending Physician: The law requires  condition of Attending Physician: The law requires  condition of Attending Physician: The law requires  condition of Attending Physician: The law requires  condition of Attending Physician: The law requires  condition of Attending Physician: The law requires  condition of Attending Physician: The law requires  condition of Attending Physician: The law requires  condition of Attending Physician: The law requires  condition of Attending Physician: The law requires  condition of Attending Physician: The law requires  condition of Attending Physician: The law requires  condition of Attending Physician: The law requires  condition of Attending Physician: The law requires  condition of Attending Physician: The law requires  condition of Attending Physician: The law requires  condition of Attending Physician: The law requires  condition of Attending Physician: The law reduints  condition of Attending Physician of Attending Physician  condition of Attending Physician  etc. (Specify)			City or Town		,	
29a. Certifier 1 Certifying Physician: To the best of Check 2 Medical Examiner: On the basis of	examination and/or investi	gation, in my opinion, d	leath occurred at t	the time, date an	d place, and due to the c	ause(s) and manner stated.
only one) 3 Certifying Nurse Practioner: To the	ne best of my knowledge, d	eath occurred at the tim 29c. License nur			cause(s) and manner as s 29d. Date signed (Month)	
1 / lakel /	1	SOU	59423	3	January 1	9.2011
30. Name and address of person who completed cause of	death (Item 23a) (Type, P	rint)			0	,
No. 1 Panha III	Stratelel C	Just 13t Re	for Me	wrottsu	January 1	1104
State	trar's Signature	backer				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical 4b. City. Town, or Location of Death 4c. County of Death Examiner HUWAK DLYMBIA Social Security Number If Under 1 Year If Under 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 **X**M 2 □ F (Month, Day, 210-09-3519 PA Director Usual Residence of Deceden ral", or items 23a or 28a-f shov Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Howard Ellicott City 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8107 Chapel Manor Lane 21043 United States 12. Was Decedent Ever in U.S. Armed Forces?
1 Ayes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 Specify: White 1 Yes 2 TNo Specify. 3 ☐ Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Westinghouse Contract Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 William Clare McFarland, Sr. Martha Nolf 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8107 Chapel Manor In. Ellicott City, MD 21043 Viola McFarland - Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 XCremation 3 Removal from State Ardent Cremation 1/20/11 Hanover, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Harry H. Witzke's Family F.H. Inc 21. Signature of Funeral Service Licenses Ollvis Columbia Pike Ellicott City MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): the attending physician and hed for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Pregnant at time of death should be detached g Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an page 2 s autopsy performed? Yes 2 No prior to completion of cause of death? after death.

Director: After this certificate 2 No 1 Yes filled in by the funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 200 Hospital 1 Tyes Other: Certificate: To 1X Inpatient 2 🗆 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifi 29c. License number မ (Item 23a) (Type, Print) State Registrar

			_ For		aryland / Dep				iene Legible.	03185
			State Registrar		Cei	rtificate of	Death	R	leg. No.	
			1. Decedent's Name (First, Middle, La	ast)				2. Date of Deat		3. Time of Death
	Physicia Medio		Loretta	Mae (Mor	t) McMill	an		Jan :	20, 2011 Year	4:45 AM
	Examin		4a. Facility Name (if not institution, give		.,		or Location of Death		4c. County of Deat	h
			615 Elm Street			Cuml	berland		Allegan	ıy
	Funeral		<ol><li>Social Security Number 6.</li></ol>	Sex 7. Ag	e (In yrs. last birthday)	If Under 1 Year Months Days		8. Date of Birth	9. Birt	hplace (State or Foreign
·	Director		214-34-0170 Usual Residence of Decedent	x	75 Yrs.			(Month, Day Sep 2	4, 1935	PA
	rland F sho	tor	10a. State 10b. County		10c. City, Town or Lo					10d. Inside City Limits
	Mary 28a- otifie	Director	MD Alle	gany	Cu	ımberland				1 □X(es 2 □ No
	h the ka or be n	a D	10e. Street and Number			10f. Zip Code			10g. Citizen of What Co	·
	ns 2% must	Funeral	615 Elm Street				21502		US/	
	deat riter iner		11. Marital Status	12. Was Decedent I Armed Forces?		Was Decedent of F If Yes, specify Cub	Hispanic Origin? (Sp an, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, White	
36	after	d by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give	<b>(</b> No	1 ☐ Yes 2 ☐ <b>X</b> io	Specify:		Specify:	white
ò	atura cal E	Completed	15. Decedent's	Year or Dates. Education	16a Dece	dent's Usual Occup	pation		16b. Kind of Business	
215	. 72 h	ם	(Specify only highest of Elementary/Seconday (0-12)	rade completed) College (1-4 or 5	(Give	kind of work done O NOT use retired	during most of wor	king	TOD. Talla of Basiness	, nacotty
217	led within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f sho ent, the Medical Examiner must be notified at		12	College (1-4 of a		nemaker			Own Hon	ne _
р	교수등	Be	17. Father's Name (First, Middle, Last,	)			18. Mother's Nar	ne (First, Middle, M	Vaiden Surname)	
/lai	ould be find Mental marked matic ev	ျ	Charles Mort				Alice	(Hill) Mort	<u>-</u>	
Maryland 21215-0036	an si		19a. Informant's Name/Relationship						City or Town, State, Zip	
	n 2		Lori Whisner	Da		O. Box 1	05		ey Ford	WV 26767
altimore,	ge 1 a it of F if ite or ot		20a. Method of Disposition 1 → Burial 2 □ Cremation 3	☐ Removal from State		matory or other pla		Date	20c. Location - City or	_
ţ	t, Pac tmer rtant		A ☐ Donation 5 ☐ Other (Spec			p Veterans		1/24/2011	Flintstor	ne MD
Bal	permit, Page 1 ar Department of He Important: If iten any injury or oth		Signature of Funeral Service Uc-	A A	22		ess of Facility pelli Funeral			
		(L. 16)	23a. Part 1. Enter the disease, or bor	polications that caused	the death. Do not ent	er the mode of dvi	Virginia Aven	ue: Cumber	land, MD 21502	Approximate
٠,	#15-0-25-Ye		23a. Part 1. Enter the disease, or con shock or heart failure. Ust only Immediate Cause (Final	one cause on each line			ng, coon ao carara	or roopiratory are	_ :	Interval Retween
	hysician/ Medical		disease o condition resulting in death)	a		9000	-			Onset and Death
20	Examiner			Due to (or as	a consequence of):					
		je.	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consequence of):					
	d ansit	Examiner	Cause (Disease or linjury that initiated events	0						
	oe executed ician and burial-transit		resulting in death) Last	Due to (or as	a consequence of):					
00		lical		d						
Box 6876	ifficat ng ph as th	Physician/Medi	IF FEMALE:							
9 ×	n cert tendir r use	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live Birth		☐ Ectopic pregnan	ncy		23d. Date of de	•
Bo	death he ath ed fo	sici	1 Yes 2 No 9 Unknown	4 ☐ Pregnant a 9 ☐ Unknown		Other (specify)			Month	Day Year
P.O.	Attending Physician: The law requires that the death certificate ard eath.  etder: the thir certificate has been signed by the attending phy. by the funeral director, page 2 should be detached for use as the		Part II. Other significant conditions	contributing to death h	ut not resulting in the	Inderlying cause a	iven in Part I	23e Did to	bacco use contribute to	the cause of death?
σ.	es the	l by	Tar II. Other significant conditions	contributing to death E	at not resulting in the t	andonying occaso g	TVOIT NIT CALL			robably 4 Onknown
rds	require been s should	Completed								
တ္တ	law r has b e 2 sl	μp						24a. Was a autop: perfor	sy prior to	topsy findings available completion of cause of
æ	: The law cate has b							1 🗆 Yes	2 No 1 ☐ Yes	2 🗆 No
ta	ysician: The is certificate director, pag	m	25. Was case referred to medical examiner?	Hospital:		26. F	Place of Death (Che			
Ξ	Physi this c al dir	은	1 Yes 2 No  27. Manner of Death	1 Inpati	ent 2 ER/Outpatie	nt 3 🗆 DOA	4 L Nursing F		ence 6 Other (Spec	ify)
0	ding I h. After funer	ate	1 Natural 5 Pending	(Month, Da	y, Year) 200. Time o	wor	ryat rk? ∐Yes 2 □ No	28d. Describe ho	ow injury occurred	
Sio	deat deat ctor: y the	Certificate:	2 Accident Investigati 3 Suicide 6 Could not	be 280 Place of Init	ury - At home, farm, str			28f Location (St	treet and Number or Ru	ral Route Number
Division of Vital Records,	l or A after Direc	Se	4 Homicide determine	building et		eet, factory, office		City or Town		rai rioute Nurribei,
	spita hours neral	ical	29a. Certifier 1- Certifying Ph	ysician: To the best of	my knowledge, death	occured at the time	e, date and place, a	and due to the cau	se(s) and manner as sta	ated.
	To the Hospital or Attending Physwithin 24 hours after death.  To the Funeral Director: After this completed filled in by the funeral di	Medical	(Check 2 Medical Exam	niner: On the basis of e	xamination and/or inves	stigation, in my opin	ion, death occurred	at the time, date ar	nd place, and due to the cause(s) and manner as	cause(s) and manner stated.
	Tott Vithi Con		29b. Signature and title of certifier			29c. Licens	se number	2	29d. Date signed (Monti	h, Day, Year)
			1/m			DE	3676	6	January	20,2011
	6V		30. Name and address of person who							
			VIKRAMADITYA F	J-M IANOS	, 934 SE	TON DR	WE CU	MBERLA	amidian	31502
	Stat Registra		31. Date filed (Month, Day, Year)	37 Registra	ar's Signat e	wed				

11-00435 Landen Mellott

anden Mellott	State of Maryland / Department of Health and Mental Hygiene  1- For State  Certificate of Death  Reg. No.	
Physician/	Registrar  2. Date of Death Month Day	3. Time of Death
ledical Examiner	Landen Allen Mellott January 15, 2011	1137 hrs
	4a. Facility Name (if not institution, give siteet and number)	ington
Funeral	5. Social Security Number 5. Sex 7. Age (iii yis. lack birdsey)	(YY) 9. Birthplace (State or Foreign
Director	209-84-9536   1\(\bigma\) M 2\(\supers\) F   1   Yrs.   Month's Days Hours   Mill.   April 8, 200	09 Pennsylvania
any	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits
<b>E</b>	Maryland Washington Hagerstown	1 Yes 2 No
Varyland 28a-f show d at once.	10e. Street and Number 10f. Zip Code 10g. Citizen of	What Country?
72 hours after death with the Maryland newstaring, or items 23a or 28a-f she at Examiner must be notified at once leted by Funeral Director	960 C Security Rd. 21742 U.S.A  11 Marital Status 12, Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-	ace - American Indian, Black,
items is the market with the market in the m	11. Marital Status 1 \( \overline{\text{Vas Decedent Ever in U.S.}} \) 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes of No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. R  14. R  15. Was Decedent of Hispanic Origin? (Specify Yes of No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 15. Was Decedent of Hispanic Origin? (Specify Yes of No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.)	hite, etc.
ufter de	1 Yes 2 No Specify: S	
hours hours Exami	15. Decedent's Education (Specify only highest grade completed)  15. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  16b. Kind of during most of working life. DO NOT use retired)	f Business/Industry
5-0036 ed within 72 hour tygiene other than the Medical Exan Completed	Selementary/secondary (0-12) College (1-7 bl 5") N / A N /	A
5-00 led wit other the M	17. Father's Name (First, Middle, Last)  18.Mother's Name (First, Middle, Maiden Surna	
Baltimore, MD 21215-0036  pemit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f sho injury or other traumatic event; the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	Joshua Allen Mellott Regina Lorraine Haw  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or	S Mellott Town, State, Zip Code)
MD 2 d 2 shou th and N a 27 is n tumatic	Regina L. Mellott-mother 960 C Security Rd. Hagerstown, MD	21742
re, rand S 1 and F Healt F Healt F item er trau	1 VRurial 2 Cremation 3 Removal from State crematory or other place)	on - City or Town, State
Baltimore, Peparline Pages 1 ar Peparlment of Her Emportant: If ite	Greenlawn Mem. Park   1-20-2011   Willi	Lamsport, MD
Balt permit. Depart Impor	21. Signature of Funeral Service Licensee  22. Name and Address of Facility Douglas A. Fie  1331 Eastern Blvd. North Hager	
Physician	23a. Part I. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or failure. List only one cause on each line.	Approximate Interval Between Onset and
/Medical	Immediate Cause (Final disease a. Sudden Unexplained Death in Childhood ( SUDIC)	Death
	or condition resulting in death)  Due to (or as a consequence of):	
ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	
led Insit	(Disease or injury that initiated events resulting in death) Last Use to (or as a consequence of):	
be executed sician and unial - transi	d.	
		te of delivery
b. Box 6876 the death certificate by the attending phy cy the attending phyched for use as the Physician/M	Solution Female: 23c. If yes, outcome or pregnancy 23c. If yes, outcome or pregnancy 23c. If yes, outcome or pregnancy 2   23c. If yes, outcome or pregnancy 2    Mont    Mont    Fetal death 3    Ectopic pregnancy    Mont     th Day Year	
OOX (eath ce attence attence for use	4 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown	
O. B at the d at the d by the trached		contribute to the cause of death?
Division of Vital Records, P.O tal or Attending Physician: The law requires that trs after death.  To Director: After this certificate has been signed by led in by the funeral director, page 2 should be dear berification: To Be Completed by Perification: To Be Completed by Perion 1.	24a, Was an 2:	Probably 4 Unknown      Were autopsy findings available
Records, I The law requires ficate has been sig	autopsy performed?	prior to completion of cause of death?
tal Rec	25. Was case referred to medical 26. Place of Death (Check only one)	1 Yes 2 No
Vital Rec yyician: The l his certificate l director, page	examiner? Hospital: 1 Inpatient 2 FR/Outpatient 3 DOA Other Nursing Home 5 Residence	6 Other: Scene
sing Phy After th funeral c	27 Manner of Death 28a Date of Injury 28b, Time of Injury 28c, Injury at Work? 28d, Describe how injury of	ccurred
sion trendi death. ctor: / y the fi	1 X Natural 5 Pending 2 Accident Investigation 2 Accident Residue (Street and Natural 1) Pending 1 Pending	umber or Rural Route Number, City
Division o spital or Attending tours after death. neral Director: Aft filled in by the fune Certification:	28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and N or Town, State)	difficilly reactive realists, sky
Hospit Hour Hour Funers		inner as stated.
Division of Vital Records, P.O. Box 68766  To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the the director. To Be Completed by Physician/Maddical Certification: To Be Completed by Physician/Madical Certification:	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, a and manner stated.	
		signed (Month, Day, Year) y 16, 2011
	30. Name and address of person who completed cause of death (Item 23a)	
	Zabiullah Ali, M.D. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223	
State	te 31. Date filed (Month, pen Year) 32. Segistrar's Signature	

				Print in Black Indelible Ink. Ensu	
			State of State Amend 29d per phys, I	Maryland / Department of Health a OR, Certificate of Death	2011 103187
	Physicia Medic		1. Decedent's Name (First, Micible, Last)  Mohe By OO	KS Nedah	2. Date of Death  Month  Day  Year  A  A  M
144.	Examin		4a. Facility Name (if not institution, give street and number Cheso peake Woods Nurs	ting Center Cambric	de Dorchester
	Funeral Director		5. Social Security Number  3.14-07-8820  1. M 2. D/F  7. Usual Residence of Decedent	Age (b) yrs. (ast birthday)  Yrs.  If Under 1 Year  If Under 2  Months Days Hours	Al Ms. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) Nary (and
	Maryland 28a-f shov otified at	rector	10a. State 10b. County  MD Dorchester	10c. City, Town or Location Cambridge	10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	h with the is 23a or 3 nust be no	Funeral Director	10e. Street and Number 3410 Beaver Neck	Road 2/6/3	10g. Citizen of What Country? 24 S A
36	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show minging or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status  1 □ Never Married 2 □ Married  1 □ Vever Married 2 □ Married  3 ☑ Widowed 4 □ Divorced  12. Was Decede Armed Force  1 □ Yes 2  If Yes, Give Year or Date	If Yes, specify Cuban, Mexican,  1 Yes 2 No Specify:	in? (Specify Yes or No- Puerto Rican, etc.)  14. Race - American Indian, Black, White, etc.  Specify: Black
21215-0036	in 72 hours e. ian "naturi Medical E	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Seconday (0-12)  College (1-4	or 5+)  16a. Decedent's Usual Occupation (Give kind of work done during most of life. DO NOT use retired)	of working
	2 should be filed within 72 th and Mental Hygiene. 77 is marked other than "traumatic event, the Mec	To Be Co	17. Father's Name (First, Middle, Last)	1 ,- 1	er's Name (First, Middle, Maiden Surname)
Maryland	2 should be th and Men 77 is marke traumatic		Win field Brook  19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number	ror Rural Route Number, City or Town, State, Zip Code) - N Road-Balt More, MD-21207
-	Page 1 and 2 s nent of Health ant: If item 27 ury or other tra		May lon Tighman  20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from St  4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of Disposition (Name of cemetery, crematory or other place)	Date 20c. Location - City or Town, State  1/21/11 Vienna, Maryland
Baltimore	permit. Page Department Important: I any injury o		21. Signature of Funeral Service Licensee	Fork Neck Cemetery  22. Name and Address of Facility  Henry Funera  Henry Funera	
	Pnysician Medical Examiner		shock, or heart failure. List only one cause on each Immediate Cause (Final disease or condition a.	used the death. Do not enter the mode of dying, such as c	Approximate Interval Between Onset and Death
	e executed cian and urial-transit	al Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events	as a consequence of):	
. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the but	Physician/Medical		rth 2  Fetal death 3  Ectopic pregnancy ant at time of death 5  Other (specify)	23d. Date of delivery  Month Day Year
ls, P.O.	requires that the de been signed by the should be detached		24 2	ath but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?  1  Yes 2 No 3 Probably 4 Unknown
Records,	he law requ te has beer age 2 shou	Completed by	7		24a. Was an autopsy findings available prior to completion of cause of death?  1 □ Yes 2 □ No
tal	cian: T ertifica ector, p	Be	25. Was case referred to medical examiner?	lout	th (Check only one)
τVï	Physic this c	<u>ان</u>	1 Yes 2 No 1 In In 27. Manner of Death 28a. Date of		ursing Home 5 Residence 6 Other (Specify)  28d, Describe how injury occurred
Division of Vital	Attending er death. ector: After by the fune	Certificate:	1 Natural 5 Pending (Month, 2 Accident Investigation 3 Suicide 6 Could not be	, Day, Year) injury work?  M 1 ☐ Yes 2 ☐  f Injury - At home, farm, street, factory, office	1 ''
Div	To the Hospital or Attending Physician: The Is within 24 hours after death.  To the Funeral Director: After this certificate ha completed filled in by the funeral director, page	Medical Ce	29a. Certifier 1 Certifying Physician: To the bes	g, etc. (Specify) st of my knowledge, death occured at the time, date and perfect of examination and/or investigation, in my opinion, death oc	place, and due to the cause(s) and manner as stated.  courred at the time, date and place, and due to the cause(s) and manner stated.
	fo the land vithin 2 to the formula omplet	Me	only one) 3 Certifying Nurse Practioner: To 29b. Signature and title of certifler	the best of my knowledge, death occurred at the time, date  29c. License number	e and place, and due to the cause(s) and manner as stated.  29d. Date signed (Month, Day, Year)
•	- > - 0		30. Name and address of person who completed cause	D D 6 3 36	59 +/19/01/19/2011
			N 11 1 7111 N D FO	2 P Ctt	MD 21613
ij.	Sta	te	31. Date filed (Month, Day, Year) 32 Reg	3 Byrn Street, Cambridge, gistrar's Signature	

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav Year **Physician** 8,2011 Ethel May NIXON Januro /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner Hagerstown Cutheran If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 6. Sex Age (th yrs. last birthday) **Funeral** Hours Davs Months 1 □ M 2 🛣 F 220-26-9843 88 Oct. 3, 1922 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Examinat must by maiffed at 1 □Yes 2KINo Directo Maugansville Maryland Washington 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Weaver Avenue 21767 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X No 14. Race - American Indian, Black White etc. 1 ☐ Yes 2X If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🏖 No Specify white Specify: <u>ک</u> 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 10 nurses aide nursing 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John R. Crabtree Emeline Robertson ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) James C. Nixon - son 13704 Village Mill Dr., P.O. Box 24, Maugansville, Md. Department of Health Important: If Item 27 any injury or other tronce. 27 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 jo 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Hagerstown, Maryland 4 Donation 5 Dother (Specify) Hagerstown Crematory 1/20/2011 22. Name and Address of Facility MINNICH FUNERAL HOME 21. Signature of Funeral Service Licensee 415 E. Wilson Blvd., Hagerstown, Md. 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 0 /Medical Due to (or as a consequence **Examiner** Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of Division of Vital Records, P.O. Box 68760, Physician/Medical the attending p for use as t 23c. If yes, outcome of pregnency 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) 1 ☐Yes 2 ☐No certificate has been signed by the irector, page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 1 ☐Yes 2 ☐No 2 No within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director, I 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27, Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1. Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Hømicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

34.4

31. Date filed (Month, Day, Year)

30. Name and address of person who completed ca

29b. Signature and title of certifier

SiDoroll istrar's Signature

State Registrar 29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 45 Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 4908 Braddock Rd. Temple Hills Prince Georges If Under 1 Year If Under 24 Hrs.

Months Davs Hours Min. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Funeral 1 🗆 M 2 🛛 F March 22, 1945 Nigeria 65 Director none Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 XYes 2 □ No Maryland Prince Georges Temple Hills 6 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 4908 Braddock Rd. 20748 Nigeria death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 24 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 0. 1 Never Married 2 Married ğ Baltimore, Maryland 21215-0036 72 hours after 1 ☐ Yes 2 ☐XNo Specify: Black "natural", Completed 3 X Widowed 4 □ Divorced Year or Dates or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 l h and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Solomon Oba Comfort Omokuse permit. Page 1 and 2 shou Department of Health and Important: If item 27 is m any injury or other traum 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Valentina Elebesunu (Daughter) 4908 Braddock Rd. Temple Hills, MD 20748 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ressurection Cemetery 1/20/2011 Clinton, Maryland 22. Name and Address of Facility Fondon/Hale Funeral Home 21. Signature of Pineral Service License 9013 Annapolis Rd. Lanham, MD 20706 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transil Cause (Disease or irrijury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy 3 Ectopic pregna 5 Other (specify) in the past 12 months?

1 Yes 2 No Month Dav Year ate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 ☐ Probably 4 ☐ Unknown Completed 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform within 24 hours after death.

To the Funeral Director; After this certificate I completed filled in by the funeral director, pag 2 No 1 Yes Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Tyes မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28d. Describe how injury occurred 28b. Time of Certificate: 28c. Injury at Natural Accident 5 Pending injury work? 2 🗌 No Investigation 6 Could not be 3 
Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Registrar

Date filed (Month, Day, Year)

and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 0700 YVETTE LATRELLE PRINCE 2011 JANUARY Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death HARFORD BEL AIR UPPER CHESAPEAKE MEDICAL CENTER If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign . Social Security Number 7. Age (In vrs. last birthdav) 8 Date of Birth 6. Sex Funeral Days Hours (Month, Day, 1 □ M 2 🕱 F 578-02-8086 39 WASHINGTON, DC Director 197 Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 No **EDGEWOOD** MD HARFORD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21040 504 ARBOR COURT USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 k Married 1 Yes 2 🔀 No 1 ☐ Yes 2X No Specify. BLACK Specify: "natural", 3 Widowed 4 Divorced Year or Dates injury or other traumatic event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) 12th College (1-4 or 5+) FEDERAL GOVERNMENT GRANTS MANAGEMENT SPECIALIST Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ELNORA ELIZABETH WILLIAMS JOHN ALBERT TOLIVER, SR 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ALPHONSO PRINCE - HUSBAND 504 ARBOR COURT, EDGEWOOD, MARYLAND 21040 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State GEORGE WASHINGTON CEMETERY 01/19/2011 ADELPHI, MARYLAND 4 Donation 5 Other (Specify) 22. Name and Address of Facility JOHNSON & JENKINS FUNERAL HOME 21. Signature of Funeral Service Licenses 716 KENNEDY STREET, NW, WASHINGTON, DC 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Multiongan disease or condition Medical resulting in death) Due to (or as a consequence of). Examiner Metastatic Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical attending p for use as t IF FFMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Pregnant at time of death Unknown 9 Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, has been signed to be a should be 1 Yes 2 No 3 Probably 4 Winknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 100 certificate ha Hospital or Attending Physician; The 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ☐ No Hospital: Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending after death. Director: Aft 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by determined within 24 hours a Medical 29a. Certifier Dertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title o certifie D63420 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 500 Upper Chisapeake State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** January 15,2011 1630 T. Thelma Parker /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Arundel Crofton er 1 Year | If Under 24 Hrs. Anne Crofton Care & Rehab. Center Birthplace (State or Foreign Country) If Under 1 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Social Security Number 6. Sex **Funeral** Hours Months Days 1 ☐ M 2 🔀 F Aug. 30, 1923 Md. 219-12-3229 Director 87 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location r 28a-f show notified at 10a. State 10b. County 1 XYes 2 No Director Upper Marlboro PG MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 23a or 'natural'', or items 23a or dical Examiner must be i United States 20772 10502 Wyld Drive Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Black, White, etc. 1 □ Never Married 2 □ Married 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 Black þ 3 ₩idowed 4 Divorced 72 hours Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Completed 15. Decedent's Education (Specify only highest grade completed) the Medical College (1-4or 5+) than Elementary/Secondary (0-12) Private Child Care Provider 12 marked other 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important; If item 27 is marked other any injury or where 17. Father's Name (First, Middle, Last) Be Thelma Harper ည Joseph Η. Collins 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 10502 Wyld Drive Robert Parker/son Upper Marlboro, Md 20772 20b. Place of Disposition ( cemetery, crematory 20a. Method of Disposition 1/24/11 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Suitland, Md. Cemetery Washington Nat. 22. Name and Address of Facility Hodges & Edwards F.H. 21. Signature of Funeral Service License 3910 Silver Hill Rd., Suitland, Md. 20746 23a. Park. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final POUL Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Concho Vascular Disea The law requires that the death certificate be executed burial-tran Division or Vital Records, P.O. Box 68760, attending physician for use as the buris Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Month Day 5 ☐ Other (specify) detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 1 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 1 No 24a. Was an certificate has b irector, page 2 sl autopsy performed? 2 **Z** No 1□ Yes To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certificat completely filled in by the funeral director, p 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 2 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3□ DOA 1 ☐ Yes Medical Certification: To 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death (Month, Day Year) Injury 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month. Dav. Year) 29c. License number 29b. Signature and ittle of certifier

State Registrar

14300 GALLANTFOX LN#222 31. Date filed (Month; Day, Year) JAN 2 1 2011

MD

pleted cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Virginia Walters Pioso 3:50 PM J<u>anuary</u> Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Prince George's Silver Spring Renaissance Gardens 8. Date of Birth (Month, Day, Ye October 8, If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min 225-05-4913 95 Fulton, Maryland **Director** Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at Director Prince George's Greenbelt Maryland 1 X Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ö Funeral with 23a 8 G Southway 20770 USA death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian Black, White, etc. ō ģ 1 Never Married 2 Married 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give and Mental Hygiene. is marked other than "natural", White Completed 3 🛭 Widowed 4 🗆 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Government Secretarial Clerk Be 17. Father's Name (First, Middle, Last) 18 Mother's Name (First Middle Maiden Sumame) ပ Raye Eugene Walters Edna Marlow 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 Michael Walters Pioso / Son 5922 Natasha Drive, Berwyn Heights, MD 20740 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot 1 

Burial 2 

Cremation 3 

Removal from State 1/19/2011 Alexandria, Virginia 4 Donation 5 Other (Specify) Metropolitan Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Says RAY Rosenis Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Pnysician/ Arteriosclerotic Cardiovascular Disease disease or condition resulting in death) Unknown Medical Due to (or as a consequence of) **Examiner** Aortic Stenosis Unknown Sequentially list conditions. Examine cause. Enter Underlying Cause (Disease or iinjury Due to for as a gonnectiering of: that the death certificate be executed Hypertension Unknown that initiated events Due to (or as a consequence of) resulting in death) Last burialphysician s the burial Medical Box 68760 attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death Physician/ 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) Yes 2 X No 9 Unknown 9 Unknown P.O. I ρ signed by Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Hospital or Attending Physician: The law requires 2 No 3 Probably 4 X Unknown Completed been si should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performe certificate 2 🗌 No 1 🗌 Yes **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' 1 Yes Other: 4 🔀 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) 2 X No ည 1 Inpatient 2 ER/Outpatient 3 DOA n 24 hours after death.

Funeral Director: After the oleted filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🛛 Natural 5 Pending work? 1 Yes 2 🗌 No Accident Investigation 6 Could not be Suicide 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. npleted 1 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the Complet Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) R158667 1/18/2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eileen Gemmell, 3160 Gracefield Road, Silver Spring, MD 20904 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2 0 2011

DHMH 17 Rev 7/2009

Registrar

			1 - For State Registrar	State	of Marylan		artment of F rtificate of		d Mental Hy	giene Reg. <b>No</b> .	011	031	93
	Physici /Medic		Decedent's Name (First, Middle	, ,	h V. Pit	tore			2. Date of De Month	Day	, 2011		of Death
1	Examin		4a. Facility Name (If not institution Carriage Hill	Nursing 1	Home		4b. City, Town, o	ethesda			0.0:4	tgomer	
	Funeral Director		5. Social Security Number 577-18-2497	6. Sex 1 🔀 M 2 🗆 F	7. Age (In yrs. <b>89</b>	Yrs.	Months Days		10/02	1921	Con	place (State intry) Mary	<i>jland</i>
	with the Maryland a or 28a-f show be notifled at	Director	Usual Residence of Decedent  10a. State 10b. County  Maryland Mon  10e. Street and Number  9904 Willo	itgomery		y, Town or Lo	10f. Zip Code	Kensin 20895	gton	10g. Citize	en of What Cou		City Limits
2-0030	filed within 72 hours after death with the Maryland Hygiene. vther than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at	eted by Funeral	11. Marital Status 1 □ Never Married 2 ⊠ Marri 3 □ Widowed 4 □ Divorced	ied 12. Was De Armed F 1 ☐ Yes If Yes, O Year or	cedent Ever in U Forces? 2 🛣 No Give Dates:	16a. Deced	1 ☐ Yes 2 ☑ No dent's Usual Occup kind of work done	dispanic Origin? an, Mexican, Po Specify: pation during most of	(Specify Yes or Nuerto Rican, etc.)		4. Race - Amer Black, White Specify: d of Business/li	ican Indian, , etc. White	2
7	ed within ygjene. ier than '	Completed	Elementary/Secondary (0-12)		(1-4or 5+)	life. L	DO NOT use retire  Car	penter			Const	ructio	ın
yland	ould be file Mental Hy arked oth atic event	To Be (		Pittore					Rose (	Gavazz	za		
Salumore, Mar	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relations  Joseph V. Pitt  20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other (S	One, Jr. 3 □Removal from	20b. F	933 Place of Dispondemetery, cremetery, cremetery	Loxford sition (Name of matory or other pla Heaven Ce 2. Name and Addre	Terrace ce) 2m. 01 ess of FacilityH	Rural Route Num.  , Silver Date  /25/2011  ines-Rinc re Ave.,	Sprin 20c. Loc Silve Udi F	ng, Mariation - City or Texts  Spring  uneral	yland Fown, State ng, MI Home,	Inc.
00,00	Physician /Medical Examiner but sthe prival-transit	dical Examiner	23a. Part1. Enter the disease, of shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)  Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Ac Due to Due to Due to Co. Is	ute Resp o (or as a conseq	irator puence of): Heart puence of). Cardiom	y Failur : Failure		diac or respiratory	arrest,		·	Between
.O. DOX 0	The law requires that the death certificate to has been signed by the attending physicage 2 should be detached for use as the	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 □ Live	outcome pf pregna birth 2 ☐ Feta gnant at time of c known	aldeath 3□	∃Ectopic pregnanc ∃ Other <i>(specify)</i> _	у		23	3d. Date of deli Month	very Day	Year
ביים	tuires that η signed bi	by	Part II. Other significant condition Chronic Atru	_							e contribute to		
II necords,	The law rectate has been page 2 shou	Completed	Urinary Trac	ct Infect	ion.				24a. Wa aut per 1∐ Yes	s an opsy formed? 2 🐼 No	death?	topsy finding completion o	is available f cause of
VII	ysician: is certific director,	To Be	25. Was case referred to medica examiner? 1 ☐ Yes 2 [X] No	Hospital:	Inpatient 2	ER/Outpatier	nt 3 DOA Oth	or:	Death <i>(Check only</i> ng Home 5 ☐ Res		□Other (Spec	cify)	
DIVISION OF	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as	Certification: T	27. Manner of Death  1 121 Natural  2	gation (Mo	e of Injury onth, Day Year) ce of injury - At h Iding, etc. (Speci	28b. Time o Injury ome, farm, str fy)	Wo		28d. Describe	how injury	occurred  Number or Ru		umber,
_	e Hospita 24 hours e Funeral letely filled	ledical C		ng <b>Physician:</b> To t <b>Examiner:</b> On the and ma									e(s)
	To the vithin To the Comp	Me	29b. Signature and title of certifie				29c. Licens				e signed (Monti		
			30. Name and address of person Tipaporn Wood		use of death (Iter	, , , , ,	Print)	017656	50 Chovu		nuary 2 o Mari		
	Sta Registr		31. Date filed (Month, Day, Year)	32	Registrar's Signa		WALL AVE	د د " وعالما	o, chevy	chas	e, mary	reariu	

DHMH 17 Rev 1/2001

1 - State Registrar

1. Decedent's Name (First, Middle, Last)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2. Date of Death

0

3. Time of Death

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January <sup>Day</sup>23. Park Young Sun 2011 0047 M Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 🛛 M 2 □ F Months Hours 1072671924 Director 214-11-5291 86 Korea Usual Residence of Decedent I and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1 Yes 2 No Maryland Prince George's Greenbelt 10e. Street and Number 10g. Citizen of What Country? 7847 Emilys Way 20770 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🖾 No Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: If Yes, Give Completed 3 Widowed 4 Divorced Asian Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b, Kind of Business Industry (Specify only highe Elementary/Seconday (0-12) College (1-4 or 5+) Clerk Korean Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Jae S. Park Young Lee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8008 Orchard Park Way, Bowie, Kum M. Park - Daughter Maryland 20715 Item 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1
Department of Important: If it any Injury or o o X Burial 2 Cremation 3 Removal from State Gate of Heaven Cem. 01/26/2011 Silver Spring, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home. Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Cardio-Pulmonary Arrest Medical resulting in death) Due to (or as e consequence of): Examiner <u>Aspiration Pneumonia</u> Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of). or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury Acute Myocardial Infarction that initiated events resulting in death) Last use as the burial-tri by the attending physician by Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ò in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death 5 Other (specify) detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed 23e. Did tobacco use contribute to the cause of death? be Dementia 1 Yes 2 No 3 Probably 4 X Unknown Completed peen : 24b. Were autopsy findings available prior to completion of cause of 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has I completed filled in by the funeral director, page 2 s autopsy performed death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Other: ည 1 Tyes 2 🗓 No 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural
Accident
Suicide 5 Pending work? 1 🗌 Yes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a, Certifier 🗵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Prominer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Cepting Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of 29c. License numbe D65069 January 23, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

Sirak Hagos

JAN 24

31. Date filed (Month, Day, Year)

M.D.

32. Registrar's Signature

Lemma.

1500 Forest Glen Road, Silver Spring.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ 2:30 ам 2011 Ettore Panetta January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Holy Cross Hospital Silver Spring Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 🗆 Months Hours (Month, Day, Year) 09/24/1925 579-50-6458 85 Italy **Director** Usual Residence of Decedent 28a-f show 10a. State 10b. Count 10d. Inside City Limits the Medical Examiner must be notified at 10c. City, Town or Location Director 1 🗆 Yes 2 🔀 No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? 23a Funeral 20902 U.S.A. 10706 Francis Drive should be filed within 72 hours after death w and Mental Hygiene.
is marked other than "natural", or items: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 X Married 乡 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give 3 Divorced 4 Divorced Caucasian Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Federal Government Machine Operator Definit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Giovanni Panetta Maria Rantucci 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10706 Francis Drive, Silver Spring, Maryland 20902 Incoronata Panetta - Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🛮 Burial 2 🗆 Cremation 3 🗆 Removal from State Silver Spring, MD Gate of Heaven Cem. 01/25/2011 4 Donation 5 Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home, 21. Signature of Funeral Service Licensee 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ Pneumonia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): that the death certificate be executed physician and the bunal-trans Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month 4 ☐ Pregnant a 9 ☐ Unknown Pregnant at time of death 5 Other (specify) Yes 2 No ed by the detached 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ate has been signed page 2 should be det Completed by Alzheimer's Dementia 2 No 3 Probably 4 🛛 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy perform death? To the Hospital or Attending Physician: The i within 24 hours after death.

To the Funeral Director: After this certificate it completed filled in by the funeral director, page **Division of Vital** Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?

1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 M Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မူ 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier 1 💹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certific 29d, Date signed (Month, Day, Year) 12 D45471 January 21, 2011

State Registrar 30. Name and address of person who completed cause

Yeheyis Negussie.

JAN 24

31. Date filed (Month, Day, Year)

M.D.

1111 Spring St., #214, Silver Spring, Maryland 20910

of death (Item 23a) (Type, Print)

Registrar's Signature

See al		State of Maryland / Department of Health and Mental Hygiene  Certificate of Death  Reg. No. 2011–03197										
É		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Decedent's Name (First, Middle, Last)					2.1	Date of Deat			3, Time of Death
	Physicia		Walter Ross						Month 「an	Day 1 3	Year 2011	5:30 A M
-	Medic Examin		4a. Facility Name (if not institution, give street and number)		4b. City, To	own, or Loc	ation of De		an		y of Death	1.7.50 A
	)		Genesis Waldorf			Wald	lorf				Char	165
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last)	birthday)	If Under 1	Year If	Under 24 F		Date of Birth	1	9. Birthp	place (State or Foreign
	Director		220-32-1093   ¹ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	Yrs.	Months	Days Ho	ours M	<sup>lin.</sup> Dc	Honth 2 <sup>Day,</sup>	1935	Mar	'yland
	3		Usual Residence of Decedent									
	sho	tor	10a. State 10b. County 10c. City, To	own or Loc	ation						1	0d. Inside City Limits
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	a or be n		10e. Street and Number		10f. Zip (					10g. Citizen of		•
	s 23	Funeral	5150 Clacton Avenue			20746				United	. Stat	es
	death item item	고	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. W	/as Decede Yes, specif	nt of Hispar y Cuban, M	nic Origin? Jexican, Pu	(Specify )	Yes or No-		ce - Americ	
98	fter c	þ	1 ☑ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No			X No Sa		TO TO THOU	1, 010.)	Specif	ck, White, 6	_
8	urs a ural'	Completed	3 ☐ Widowed 4 ☐ Divorced Year or Dates.		L 163 Z	25.110 0,	Doony.			Specify	<i>,</i> . <b>D L U</b>	
5	"nai "nai	ble	15. Decedent's Education 1 (Specify only highest grade completed)	(Give k	ind of work	Occupation done during		working	1	16b. Kind of E	Business Inc	dustry
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2	d wit Hygie ther nt, th	0	17. Father's Name (First, Middle, Last)	bus D	TTAGE			N. 1				Hansic
Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any fiurry or other traumatic event, the Medical Examiner must be notified at once.	To B	Percy Ross			18.		Name (FIR 7 Wil		laiden Surnarr	ie)	
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ţi	t. Pa tmer rtant rjury				Mem.			21/1		Easto		
Baltimore,	permir Depar Impor any in		21. Signature of Funeral Service Licensee  Janice Edwards per DVR			Address of	-		_			eral Home
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ĕ	the a	ysic	1  Yes 2 No 4 Pregnant at time of deal 9 Unknown 9 Unknown	III 5 L	Other (spe	Ciry)						,
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Division of Vital Records,	or A	Certificate:	4 Homicide determined 28e. Place of Injury - At home building, etc. (Specify)	, tarm, stre	et, factory,	omice			City or Town		ber or Hurai	Route Number,
Ω	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 42 hours after death.  To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transic completed filled in by the funeral director, page 2 should be detached for use as the burial-transic completed filled in by the funeral director, page 2 should be detached for use as the burial-transic completed filled in by the funeral director, page 2 should be detached for use as the burial-transic completed filled in by the funeral director, page 2 should be detached for use as the burial-transic completed filled in by the funeral director, page 2 should be detached for use as the burial-transic completed filled in by the funeral director, page 3 should be detached for use as the burial-transic completed filled in by the funeral director, page 3 should be detached for use as the burial-transic completed filled in by the funeral director, page 3 should be detached for use as the burial-transic completed filled in by the funeral director, page 4 should be detached for use as the burial-transic completed filled in the funeral director for the funeral director for the funeral director for the funeral director for the funeral director for the funeral director for the funeral director for the funeral director for the funeral director for the funeral director for the funeral director for the funeral director for the funeral director for the funeral director for the funeral director for the funeral director for the funeral director for the funeral director for the funeral director for funeral director for the funeral director for the funeral director for the funeral director for funeral director for funeral director for funeral director for funeral director for funeral director for funeral director for funeral director for funeral director for funeral director for funeral director for funeral direct		29a. Certifier 1 X Certifying Physician: To the best of my knowledge	ne death -	Coursed of 18	he time det	o and plan	e and die	e to the serv	eals) and man	ner se state	ad
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	•		30. Name and address of person who completed cause of death (Item 23	a) (Tuno P							1	- 1
			Josjin Vazhappilly, 2007 Tidewat			Drive	e, An	napo]	lis MD	2140	1	
	Stat	e_						-				
	Registra		31. Date filed (Month, Day, Year)  NAR 1 5 2011  32. Registrar's Signature	B. K	park	-						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JAN.17 W. RENAIRI BLANCHE 2:00 PM 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death MONTGOMERY MANOR CARE NURSING HOME BETHESDA Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 6. Sex Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 X F Days Hours Min. 216-44-9432 104 MARYLAND Director SEPT. 906 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD. MONTGOMERY BETHESDA 1 X Yes 2 No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? ?7 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be Funeral 5900 JARVIS LANE 20814 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married 1 ☐ Yes 2X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: WHITE Completed 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) MEDICAL SECRETARY NAVAL MED.CENTER Be 17. Father's Name (First, Middle, Last) th and Mental h 18. Mother's Name (First, Middle, Maiden Surname) ပ WHEELER HARRY L. WHEELER ANNIE B. permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13008 KIDWELL, WOODBRIDGE, VA. 22193 RICHARD RENAIRI- SON 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Durial 2 X Cremation 3 Removal from State METROPOLITAN CREM Japo119 ALEXANDRIA, VA. 4 Donation 5 Other (Specify) 22. Name and Address of Facility 2222-WISCONSIN AVE., NW Signature of Funeral Service Lice HYSONG CO. WASHINGTON, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of leach line. Approximate Interval Between shock, or heart failure. List only one cause or Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ Van Demo Medical Due to (or as a consequence of) xaminer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Examin The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last physician a sthe burial-Physician/Medical Box 68760 attending p for use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Pregnant at time of death Dav Year signed by the a d be detached f 1 ☐ Yes 2 L 9 ☐ Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed should been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy perform death? Yes of Vital completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) this Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at After 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death. To the Funeral Director: After 1 Natural iniury 5 Pending work? Division 2 No Investigation 2 Accident
3 Suicide
4 Homicide Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🖊 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0)005 U 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ulive 9801 Creangia Arnu State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Amelia Baptista Romero J'4911. 20, 2011 Year 12:15p M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Montgomery Genesis Woodside Silver Spring Social Security Numbe If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 577-96-0289 1 □ M 2 🏻 F Hours 7 *[<sup>M</sup>2" <sup>H</sup> P* F F F F 1) 1 Bollivia Director 99 Usual Residence of Decedent ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director MD Montgomery Silver Spring 1 🗆 Yes 2 💆 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 8817 Lanier Drive 20910 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto\_Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 11. Marital Status 14. Race - American Indian, Black, White etc. White Completed by 1 Never Married 2 Married 1 Yes If Yes, Give within 72 hours after Baltimore, Maryland 21215-0036 Bolivian 1 XYes 2 ☐ No Specify: 3 🛚 Widowed 4 🗆 Divorced Specify: Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired)

Homemaker (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Own Home other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Cornelia Nina Enrique Romero 19a. Informant's Name/Relationship (Type, Pridaughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2211 Seminary Road Silver Spring, Md 20910 Carmen Baptista de Guzman, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Gate of Heaven any injury or 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State 1/22/2011 Silver Spring, Md 4 ☐ Donation 5 ☐ Other (Specify) Funeral Servic Coenses 21. Signat ve PHATLIP domes of TWALDI FUNERAL SERVICE, P.A. 9241 Columbia blvd.Silver Spring, Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease or impry that initiated events e attending physician and ed for use as the burial-transit s a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month signed by the a d be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ cate has been signated by page 2 should by Completed 1 Tes 2 1 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy performed? death? 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 🔀 Nursing Home 5 🗌 Residence 6 🗆 Other (Specify) 2 🔀 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Jan. 21, 2011 H67624 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

Sultan J.Afrooz

JAN 24

31. Date filed (Month, Day, Year)

Greenway Center Dr. Greenbelt, Md 20770

7525

32. Registrar's Signature

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		Please	Type or Print in I State of Marylan						Legib					
		State Registrar		Cer	tificate of L	Death		Reg. No.	LUI	03200				
Physicia	n/	1. Decedent's Name (First, Middle, Las					2. Date of De Month		, 20 <sup>°</sup> 1	3. Time of Death				
Medic	al	Alfred Bifield  4a. Facility Name (if not institution, give	Riley	-	4h City Town o	r Location of Death	Januar		County of E					
Examin	er	14801 Pennfield			**	r Spring			lontgo					
Funeral		Social Security Number     6. S	ex 7. Age (In yrs. la		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bird	th ı <i>y, Year)</i>	9.	Birthplace (State or Foreign Country)				
Director		579-20-9582 Superior State of December 1	87	Yrs.			Jan. 5,	192	24	D.C.				
and show dat	tor	10a. State 10b. County	10c. City	y, Town or Loc	cation					10d. Inside City Limits				
Mary 28a-f otifie	Director	MD Montg	omery S	Silver	Spring					1 🗆 Yes 2 🗗 No				
th the 3a or the n		10e. Street and Number	"011		10f. Zip Code			-	izen of What	t Country?				
ath wi	Funeral	14801 Pennfield  11. Marital Status	12. Was Decedent Ever in U.S	5. T13. V	20906 Vas Decedent of H	ispanic Origin? (Sp	ecify Yes or No-	US		American Indian,				
ter de or ite miner	by F	1 Never Married 2x Married	Armed Forces? 1 ★ Yes 2 □ No	H	Yes, specify Cuba	an, Mexican, Puerto	Rican, etc.)		Black, V	/hite, etc.				
ursat tural", al Exa	ted	3 🗆 Widowed 4 🗆 Divorced	If Yes, Give Year or Dates. 1943	45	Yes 2 X No			T	<sup>Specify</sup> Wh					
72 ho n "nat 1edica	Completed	15. Decedent's E (Specify only highest gr	ade completed)	(Give A	lent's Usual Occup kind of work done ( D NOT use retired)	during most of wor	king	16b. Ki	ind of Busin	ess Industry				
within jiene.		Elementary/Seconday (0-12)	College (1-4 or 5+) <b>5 +</b>		nical En			Fed	deral	Government				
filed y		17. Father's Name (First, Middle, Last)				18. Mother's Nar			Surname)					
uld be I Ment narke natic (	입	Wallace Riley				L	lia Bifi			Zin Code) 20906				
2 sho th and 27 is n traun		19a. Informant's Name/Relationship (7) Anne Riley/Wife	ype, Print)			and Number or Ru eld Circ				Spring, MD				
f and f Heal item other		20a. Method of Disposition		lace of Dispo	sition (Name of		Date	20c. Lo	ocation - City	y or Town, State				
Page nent c ant: If any or		1 ★Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specit	Helilovai irolfi State		oln Ceme	tery 2	$0.1^{24}$	Bre	entwoo	d, MD				
Namit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Hygiene with them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licens	./ .	22 F	Name and Addre	ss of Facility Collin	s Funera	al Ho	ome In	c. ing, MD 20901				
<u>a.u = a o</u>	Н	23a. Part/1. Enter the disease, or com	MO 150						er Spr	ing, MD 20901 Approximate				
hi.i/		shock, or heart failure. List only o	ne cause on each line.				or roophatory a	1001,		Interval Between Onset and Death				
hysician/ Medical		Immediate Cause (Final disease or condition resulting in death)  Fnd-Stage Parkinson's Disease  Due to (or as a consequence of):												
Examiner		Sequentially list conditions,												
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that the death	Physician/Medica	1  Yes 2 No 9 Unknown	9 Unknown	Jean 3 L	Other (specify) _									
requires that the de been signed by the should be detached	by PI	Part II. Other significant conditions of	ontributing to death but not res	ulting in the u	nderlying cause gi	ven in Part I.	23e. Did t	obacco u	ise contribut	e to the cause of death?				
quires en sig ould b	ted	Congestive Heart	Failure, Coro	nary A	rtery Di	sease	1 🗆	Yes 23	No 3	Probably 4 Unknown				
law re las be e 2 sho	Completed						24a. Was auto	psy		e autopsy findings available to completion of cause of				
icate l		25. Was case referred to medical					1 🗆 Yes	ormed? 2 Sel No		Yes 2 No				
/sıcıar s certii directo	To Be	examiner?  1  Yes 2  No	Hospital:	EB/Outpatier	Oth	er:  A Nursing b	lome 5 😾 Resi	dence 6	Other (S	(necify)				
ig Finy ter this neral o		27. Manner of Death 1 Natural 5 Pending	28a. Date of injury (Month, Day, Year)	28b. Time of injury		y at	28d. Describe I			pesny				
rendir leath. or: Af the ful	ifica	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	n e		M 1 🗆	Yes 2 No								
al or An s after d I Direct d in by	Certificate:	4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify		eet, factory, office		28f. Location ( City or Tov			r Rural Route Number,				
To the hospital of witherang enjsteran: The law requires within 24 hours after death.  To the Funeral Director: After this certificate has been sign completed filled in by the funeral director, page 2 should be	Medical	(Check 2 Medical Exam	sician: To the best of my know iner: On the basis of examination se Practioner: To the best of m	n and/or invest	tigation, in my opini	on, death occurred	at the time, date a	and place,	, and due to	the cause(s) and manner stated.				
1 To within	2	29b. Signature and title of certifier				D30484				onth, Bay, Year)				
		30. Name and address of person who Charles Umosell	completed cause of death (Item	23a) (Type, F Cxc:n H	Print) Hill Road	1, #704,	Oxon Hi	11, N	MD 207	745				
Stat	te 🔌	31. Date filed (Month, Day, Year)	32/Registrar's Signa		del.		• • • • • • • • • • • • • • • • • • • •							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Bedford S. Roberson, Jr. JANUAR Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Lanham Doctor's Community Hospital If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, **Funeral** Min (Month, Day, Year) 1922 1 X M 2 D F Months Days Hours North Carolina 88 Director Aug. 577-38-9111 Usual Residence of Decedent Important, If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 No MD Anne Arundel Crofton 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral USA 1809 Roxboro Place 21114 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces
1 Yes 2 þ 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify:White 3 Widowed 4 Divorced Completed Year or Dates. WWII 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Warehouse & Delivery Elementary/Seconday (0-12) College (1-4 or 5+) Service Owner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Marian Helen Doggett Bedford S. Roberson, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bedfor of 7130 Fairway Bend Lane, Unit 190, Sarasota, FL permit. Page 1 and 2 s Department of Health Department of Health Important; If item 27 Joan Bow / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 1/14/2011 Baltimore, MD 21. Signature of Funeral Solvice Licensee Beall Funeral Home 22. Name and Address of Facility 6512 NW Crain Hwy., Bowie, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each lie Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examin that the death certificate be executed ig physician and as the bunal-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 attending properties for use as IF FFMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day Pregnant at time of death 5 Other (specify) Yes 2 □ No ed by the a detached f 9 Unknown 9 Unknown s been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š the Hospital or Attending Physician: The law requires 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has I page 2 s autopsy perform this certificate 1 Yes 2 No Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2'1 No 1 1 Inpatient 2 ER/Outpatient 3 DOA
28a. Date of injury
(Month, Day, Year) 28b. Time of injury
(month, Day, Year) 28c. မ To the Hospital or Attending Physis within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir 27. Manner of De th Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🗶 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation in my entities, death accurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 4 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) MBB 20464 80 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

gistrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death REILLY Physician/ Medical 2 () DINM 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Anne Arundel Annapolis Spa Creek Social Security Number If Under 1 Year If Under 24 Hrs Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 D F Oct. 27 Months Hours 1935 Director 037-22-6290 75 Rhode Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Millersville Anne Arundel MD 1 ☐ Yes 2 🛛 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 1770 Baldwin Dr. 21108 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Was Decedent Ever in U.S. 14 Race - American Indian. Armed Forces?

1 2 Yes 2 No Black, White, etc. 1 Never Married 2 X Married 2 Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: If Yes Give 3 Widowed 4 Divorced Completed Year or Dates.1953-57 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) U.S. Government Manager at NSA Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Rose Viviani James Reilly 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Millersville, MD 1770 Baldwin Dr., Emily M. Reilly / Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Our Lady of the Fields 1/17/2011 4 ☐ Donation 5 ☐ Other (Specify) Millersville, MD 21. Signature of Funeral Service Lions Beall Funeral Home 22. Name and Address of Facility Bowie, MD 6512 NW Crain Hwy., rart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Physician. Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attending physician and I for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ Live Birth 2 Fetal death in the past 12 months? Month Day Year Pregnant at time of death 2 No Yes ed by the Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. signed det 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2 s autopsy performed 1 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Tyes 2-No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director After this completed filled in by the funeral 27. Manner of Death 28a. Date of injury 28h. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: (Month, Day, Year) 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 ☐ Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basic of examination and/or investigation and/or investigation. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of centif 20 104 egistrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last)\_ 2. Date of Death 3. Time of Death **Physician** josephine 110.0100 2011 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Hageistown washing-lon NW2 01 Hare 15 town If Under 1-Year | If Under 24 Hrs. 6. Sex 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 ☐ M 2 🔀 F 69 214-76-4032 Director July 19,1941 Maryland Usual Residence of Decedent 10c. City, Town or Location 7 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the M-di-al Examiner must be notified at 10a, State 10b. County 10d. Inside City Limits 1 X Yes 2 No Director Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 806 Maryland Avenue 21740 USA Funeral filed within 72 hours after death 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Specify: white Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ne any Injury or other traumatic event, the Medis once. Elementary/Secondary (0-12) College (1-4or 5+) unknown unknown unknown unknown 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Thomas J. Rowland Josephine Frances Socha 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael T. Rowland - brother 384 Shady Ave., Steubenville, Ohio 43952 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ♣ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown Crematory 1/19/2011 Hagerstown, Maryland 21. Signature of Euroral Service Licens 22. Name and Address of Facility MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events and the cauthors of the cart things in footbly not the cauthors of the cart things in footbly not the cauthors of the cart things in footbly not the cart things in footbly not the cart things in footbly not the cart things in footbly not the cart things in footbly not the cart things in footbly not the cart things in footbly not the cart things in the cart the death certificate be executed attending physician and for use as the burial-transit onur resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 □Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) certificate has been signed by the rivector, page 2 should be detached 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Nursing Home 5 | Residence 6 | Other (Specify) Hospital: 2 No 1 Tyes 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To this funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t Attending 5 Pending investigation Natural Injury death. 1 ☐ Yes 2 ☐ No 2 Accident I or Attend after death Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital within 24 hours a To the Funeral C 29a. Certifier (Check only one) 1 Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) warrance 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mush Pike Hugers 14014

54-1 State

31. Date filed (Month, Day, Year)

suphunie

oncordic 32. Registrar's Signature

JAN 20

amer

(RNP

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 23 Year ZUII Physician/ 7:33 AM RAINES HUGHTE OUSERT Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** ST, MARYS MARYES LEUNARD TOWN HUSPITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Security Numbe 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 MM 2 □ F (Month, Day, Year) 12/08/1949 Washington, **Director** DC 577**-**66**-**7842 Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 ☐ Yes 2 🔼 No Mechanicsville Maryland St. Mary's 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 20659 37948 George F. Drive Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 🖾 No Black, White, etc. Ş 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: If Yes Give Specify: White Completed 3 - Widowed 4 - Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Plumbing Company Plummer 4 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Hughie Morgan Raines 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 37948 George F. Drive, Mechanicsville, MD 20659 Linda D. Raines/Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State Brinsfield-Echols 01/25/2011 Charlotte Hall, MD 4 Donation 5 Other (Specify) Laward N. Brinsfield, <sup>22</sup> Name and Address of Eacility Brinsfield—Echols Funeral Home, F P.O. Box 128, Charlotte Hall, MD Jr. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final INFARCTION Physician 140 CARPTAL disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentiary fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner YEARS attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed TWEN CHOLESTERCY that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death
Unknown signed by the a d be detached for 1 Yes 2 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by OPSISIT 1 Yes 2 No 3 Probably 4 Unknown should been 24b. Were autopsy findings available prior to completion of cause of death? ABETES 24a. Was an After this certificate has funeral director, page 2 s autopsv performed? Yes 2 No MENTENSZON 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital: 1 Yes 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural injury 5 Pending Accident Investigation after death 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide filled in by determined City or Town, State) 24 hours Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. сотретер (Check within 2 3 [ only one) 29b. Signature and title of 29d. Date signed (Month, Day, Year) in ZOIL

State Registrar 75500

POINT LOOKELLT RD, LEONANTOWN MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

RUBERT

31. Date filed (Month, Day, Year,

GZBSON, MD

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Taleb Rezaeidogaheh January 28, 2011 15:25 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Shady Grove Adventist Hospital Rockville 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1**√** M 2 □ F Months March 21 1933 IRAN 77 212-73-0394 Director Usual Residence of Decedent shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Maryland Director or 28a-f sh notified 1 🗆 Yes 2 🔀 No Maryland Montgomery Germantown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò ed other than "natural", or items 23a or event, the Medical Examiner must be Completed by Funeral with 20874 Iran 8 Stags Leap Court 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian Armed Forces?

1 Yes 24 No Black, White, etc 1 Never Married 2 Married White 1 Yes 2 No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Page 1 and 2 should be filed within private Accountant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ permit. Page 1 and 2 should be fi Department of Health and Mental Important: If item 27 is marked any injury or other traumatic ev gnoe. Rayhan Zarifi Dogaheh Ali Rezaei Dogaheh 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
8 Stags Leap Court Germantown, MD 20874 19a. Informant's Name/Relationship (Type, Print) Atri Hashemi Dogaheh -wife 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Parklawn Mem. Park 2/1/2011 Rockville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Bonald Wess Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ malignant arrhy thmia disease or condition resulting in death) minutes Medical Due to (or a consequence of): Examiner months 015295C stane rena Sectiontially list nunditions Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4 Pregnant 9 Unknown Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 Probably 4 🖒 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director. upleted filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) Other (Specify) Hospital 2 🗆 No ၉ 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 27. Manner of Death 28b. Time of 28d. Describe how injury occurred injury 1 Natural 5 Pending 2 No Investigation
6 Could not be Accident 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier A4+841 January 28, 2011

Registrar

State

29,2011

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PO O A TUT

Maryland 21215-0036

Baltimore,

Division of Vital Records, P.O. Box 68760

Medical center Drive, Rockville, manyland 20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

9901

32 Registrar's Signature

Emily Gordon,

31. Date filed (Month, Day, Year)

ROHRER, PAULINE MAS

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		•	For State Registrar	Otato or ivi	ar yrarre	•	tificate			u	·o····	Reg. No.		03205
	Physicia	n/	1. Decedent's Name (First, Middle, Last) Pauline Mae Ro	hrar							2. Date of De Month	Davi	Year	
- 4,	Medic Examin		4a. Facility Name (if not institution, give str	and number	AUTIM	1025	4b, City To	own, or	Location o	of Death	JANU	4-1 6	201 unty of Dea	
	Funeral		5. Social Security Number 6. Sex		e (In yrs. las		If Under 1	, ,	If Under Hours		8. Date of Bir	th ay, 8° ar 193	9. B	irthplace (State or Foreign
	Director		Usual Residence of Decedent	^							Aprii	0,190	/	
	Maryland 18a-f sho tified at	Director	Md. Washin	gton	10c. City,	Town or Loc Smi	thsbu	ırg						10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	with the I 23a or 2 ist be no	Funeral Di	10e. Street and Number 22716 Cavetown Ch	urch Rd.			10f. Zip C	Code	21	1783		10g. Citizen	of What C	Country? .S.A
980	within 72 hours after death with the Maryland glene. er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	Completed by Fun		2. Was Decedent E Armed Forces? 1  Yes 2 If Yes, Give Year or Dates.		1 "	Vas Deceder Yes, specify	y Cubar	n, Mexicar	n, Puerto	cify Yes or No- Rican, etc.)		Black, Wh	nerican Indian, ite, etc. White
15-0	"2 hour "natu edical	plete	15. Decedent's Educ (Specify only highest grade			(Give F	ent's Usual	done di	ition uring mos	t of worki	ng	16b. Kind	of Busines	s Industry
2121	within 7 giene. er than t, the M		Elementary/Seconday (0-12)	College (1-4 or 5	i+)	life. Do	NOT use n H <b>o</b> me		er				Н	ome
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygie Important: If item 27 is marked other i any injury or other traumatic event, the <u>once.</u>	To Be	17. Father's Name (First, Middle, Last)  I van C. Stot	tlemyer					18. Moth		e (First, Middle, ogie S.		ame)	
, Mar	nd 2 shou ealth and m 27 is m ner traum		19a. Informant's Name/Relationship (Type Samuel E. Rohrer (			19b. Mailin 22 <b>71</b> 6	g Address (S Cave	Street a	n <sup>d Numbe</sup> n Cht	er or Rura Urch	Route Number Rd. Sm	i thsbu	n, State rg , Mo	2. 21783
imore	Page 1 a ment of H ant: If ite ury or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	St.	ace of Dispo metery, crem Mark Chur	natory or oth S Lut	er place the r	an .	20	. 27, 011	1	•	or Town, State
Balt	permit. Departi Import any inj		21. Signature of Funeral Service Licensee	hwis	MO141	22	. Name and	Addres:	s d'Facilit	eral				ury Ave. Md. 21783
4	hysician/		23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition	cause on each line	1500	VOY IU		of dying	, such as	cardiac c	r respiratory a	rest,	-	Approximate Interval Between Onset and Death
	Medical Examiner		resulting in death)  Sequentially list conditions, b.	Due to (or as a	a conseque	ence of):	LACT	10	VF	CT	12/			
	executed an and ial-transit	Examiner	rany, leading to himmediate cause. Enter Underlying Cause (Disease or iinjury that initiated events	Due to (or as t										
	te be exec nysician al he burial-t	_	resulting in death) Last	Due to (or as a	a conseque	ence of):								
P.O. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	c. If yes, outcome  1  Live Birth  4  Pregnant a  9  Unknown	2 Fetal	death 3	Ectopic pro Other (spec		У			23d	Date of o	delivery Day Year
ds, P.0	quires that t en signed by	by	Part II. Other significant conditions cont	ributing to death b	ut not resu	Iting in the u	nderlying ca	ause give	en in Part	l.	23e. Did 1			to the cause of death?  Probably 4 Unknown
Division of Vital Records,	<b>sician:</b> The law rec certificate has be rector, page 2 sho	Completed					<u>-</u>				24a. Was auto perfe 1 \(\sum \) Yes		prior to death?	autopsy findings available o completion of ouse of es 2 \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \
/ital	rsician s certifi director	To Be	25. Was case referred to medical examiner?  1 ☐ Yes / 2 ☐ No ☐ Ho	spital:	ent 2 🗆 E	R/Outpatien	t 3 🗆 DO4	Othe	r· _		ne 5 🗆 Resi	dense 6 🗆	Othor (Sa	aciful
on of	To the Hospital or Attending Physician: The law within 24 burus after death.  To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2		27. Mann F of Death  1 Natural 5 □ Pending 2 □ Accident Investigation	28a. Date of injur (Month, Day	ry 2	28b. Time of injury		c. Injury work?	at		28d. Describe			Sony
Division	al or Atte s after des I Director d in by th	Certificate:	3 Suicide 6 Could not be determined	28e. Place of Inju building, etc		ne, farm, stre	eet, factory,	office			28f. Location ( City or To		mber or F	Rural Route Number,
_	To the Hospital or Attending I within 24 hours after death.  To the Funeral Director: After completed filled in by the funer	Medical	29a. Certifier (Check 2 Medical Examine only one)  29a. Certifying Physicl Medical Examine only one)	r: On the basis of ea	xamination	and/or invest	igation, in m	y opinio	n, death o	ccurred at	the time, date	and place, and	due to the	e cause(s) and manner stated
	To the vithing to the complete		29b. Signature and title of certifier	~	M	)			number			ood Date d		nth, Day, Year) -1/ 23 2011
	AV		30. Name and address of person who com	pleted cause of de	eath fitem :	23a) (Type, P	rint)	Hus			C BAL			
ļ	Sta Registra		31. Date filed (Month, Day, Year) FEB 0 7 201	32. Agistra	ar's Signatu	8. p	arked	,						

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 8 2 0°1 1 Salmond Nathan January 2005 P M Medical 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death Examiner 4c. County of Death Prince George's Prince George's Hospital Cheverly Birthplace (State or Foreign Country)
 C 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 56 yrs 8. Date of Birth **Funeral** Days 1 🛛 M 2 🗆 F Hours Min (Month, Day, Year) 54 577-76-0949 Director Usual Residence of Decedent 28a-f show 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.
item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Capitol Heights Prince George MD 1 Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20743 5016 Gunther Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Black, White, etc.
Black Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Completed by 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 K No Specify: Specify: 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Technician Landscaping Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Henry Edward Harris Bessie Mae Salmond <sup>19a.</sup> Informant's Name/Relationship (Type, *Print*) Contrice Colbert-Daughter o. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 366 Curtis Dr. #303 illcrest Heights, MD 20746 permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Riverdale Park Cre01/24/201 1 🗆 Burial 2 🔀 Cremation 3 🗆 Removal from State Riverdale, MD 4 Donation 5 Other (Specify) 22 Name and Address of FacilitDL 2019 MLK Jr Ave aughlin Funeral Home Washington DC 20020 21. Signature Funeral Service Licensee art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betweer shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ 000 Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or s a consequence of) that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a coffs resulting in death) Last attending physician a for use as the burial-Physician/Medical 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IE FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Day Year 1 Yes 2 9 Unknown been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 ☐ No 3 ☐ Probably 4 X Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy death? performe this certificate 1 🗌 Yes the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No 1 Tyes Other: ۵ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) To the Hospital or Attending Ph within 24 hours after death.

To the Funeral Director: After th completed filled in by the funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🔼 Natural 5 Pending injury work? Division 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signat and title of certifie 29d. Date signed (Month, Day, Year) 29c. License number Januen address of person who completed cause of death (Item 23a) (Type, Print) TINCE State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

Box 68760

P.O.

Records,

of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Charles Edward Saul 5:30 Ам 2011 January Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Crofton Convalescent Center Anne Arundel Crofton Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, **Funeral** Days Hours 1 **X** M 2 □ F Months Washington, 80 214-28-9639 1931 Director January 4. Usual Residence of Decedent show 10d. Inside City Limits 10b. County 10c, City, Town or Location with the Maryland 10a, State Director ral", or items 23a or 28a-f s Examiner must be notified 1 X Yes 2 No Prince George's Edmonston Maryland 10f. Zip Code 10e. Street and Number 10g Citizen of What Country? 20781 5118 Crittenden Street USA 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status 12 Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 X Never Married 2 Married þ Baltimore, Maryland 21215-0036 res, Give Year or Dates. KOREAN 1 ☐ Yes 2 🗓 No Specify: Specify: White "natural", 3 Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Glass Glazier 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Goldie G. Marshall Charles A. Saul or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1724 Tedbury Street, Crofton, MD 21114 Sandra S. Mattison / Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Page 1 a
Department of H
Important: If ite 1 X Burial 2 Cremation 3 Removal from State 1/21/2011 Brentwood, Maryland Fort Lincoln Cemetery injury o 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Rity Rugas Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death 30 Minutes Immediate Cause (Final Physician/ Sudden Cardiac Death disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner 5 Years Coronary Artery Disease Sequentially list conditions, Due to lor as a consuguence of cause. Enter Underlying Exami Cause (Disease or iinjury The law requires that the death certificate be executed attending physician and for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?

1 Yes 2 No Year Pregnant at time of death 5 Other (specify) ed by the detached P.O. cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Congestive Heart Failure Division of Vital Records, 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Chronic Obstructive Pulmonary Disease 24a Was an autopsy performed? Yes 2 No After this certificate 1 Yes 2 No Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 🗷 Nursing Home 5 🗌 Residence 6 🗌 Other (Specify) 1 Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 I DOA ျ nours after death.

neral Director: After this if filled in by the funeral di 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: To the Hospital or Attending within 24 hours after death. 1 X Natural 5 Pending 1 Tes 2 🗌 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier peted Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 29c. License numbe 29d. Date signed (Month, Day, Year)

Registrar

Paul Bruce Berez, 2225 Defense Highway, Suite E, Crofton, MD 21114

30. Name and address of person who completed cause of seath (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

D29571

1/17/2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ 2011 11:50pm Sol Shaz Januaru Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Rockville Casey House 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Canada 1 🕅 M 2 □ F Months Days Hours 1407th Day 1927 83 161-42-5879 Director Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland Director 1 Yes 2 No Rockville Maruland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral U.S.A 20853 14524 Chesterfield Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 White 1 Yes 2 No Specify: Completed 3 Widowed 4 Divorced the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Page 1 and 2 should be filed within 73 ment of Health and Mental Hygiene. ant; If item 27 is marked other than ury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Medical 5+ Thoracic Suraeon Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Moses Joseph Schwartz Leah Lazanik 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14524 Chesterfield Road, Rockville, Maryland 20853 Victoria Shaz - Spouse 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date Department of H Important; If ite any injury or ot once. cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Judean Memorial Grdns: 01/24/2011 Olney, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. . Signature of Funeral Service Licenses 11800 New Hampshire Ave., Silver Spring, MD 20904 upplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximate Interval Between Onset and Death Weeks 23a. Part 1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final Ph sician/ Cerebral Embolism disease or condition resulting in death) Medical Examiner Atrial Fibrillation Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or linjury Directo for as a nonsecularité of To the Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events Due to (or as a consequence of) resulting in death) Last use as the burialthe attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? ģ Month Dav Year Pregnant at time of death 5 Other (specify) 2 No as been signed by the a 2 should be detached g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛛 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy page performed 1 ☐ Yes 2 ☐ No 1 Yes 2 X No funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 2 1X No ြု 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 X Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury 1 X Natural 5 Pending iours after death.

Ieral Director: Aft
filled in by the fur 1 Yes 2 No Investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined within 24 hours at To the Funeral Di Medical 1 🗶 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 🗌 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 1-23-2011 D37142

Registrar

1355 Piccard Drive.

Registrar's Signatur

assa s

Suite 100, Rockville, Maryland 20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.,

Geoffrey Coleman,

24

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 634 A M Physician/ Month Deborah Ann Smith 201 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 10907 Tennebrook Road Washington Hagerstown 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8, Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🔀 F Days (Month, Day, Year)
March 27,1950 Maryland Hours Min. Months 60 **Director** 218-50-2502 Usual Residence of Decedent fshow ould be filed within 72 hours after death with the Maryland Mental Hygiene.

marked other than "natural", or items 23a or 28a-f sho "natural", or items 23a or 28a-f sho 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 Tes 2 No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10907 Tennebrook Road 21740 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Secretary Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Malcolm Calvin Clouser, Jr. Evelyn Gay Semler . Page 1 and 2 should b ment of Health and Mer tant: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Glenn L. Smith (Husband) 10907 Tennebrook Road Hagerstown, Maryland 21740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Department of Important: If it any injury or o 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) St Marks Episcopal Cem. 1-24-2011 Boonsboro, Maryland 21. Sanature I) um ral Service L 22. Name and Address of Facility Osborne Funeral Home P.A. 425 S. Conococheague St. Williamsport, MD 21795 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Break Finysician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the Innerial director, page 2 should be detached for use as the burlansit Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day Yea Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 □ Probably 4 □ Unknown Completed 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 Yes 2 No Accident Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

DHMH 17 Rev 7/2009

only one)

29b. Signature and title of certifier

egistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

41667

Nedscal Camos

			State of Maryland / Department	artment of Health and M <i>rtificate of Death</i>		ené UTI UDZIZ
			Registrar  1. Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death
	Physicia		John Glenn SMITH		Month January	20, 2011 2:00 a. M
•	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
	LXamin	-	NMS of Hagerstown	Hagerstown		Washington
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Y	(ear) 9. Birthplace (State or Foreign Country)
	Director		218-30-0737 1≅M 2□F 80 Yrs.	Months Buys 110010	Sept. 8,	1930 Maryland
Т	p ,		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Lo	ncation		10d. Inside City Limits
	aryla shov	-				1 ☐ Yes 2🏝 No
	he M	ect	Maryland Washington Hagers  10e. Street and Number	10f. Zip Code	100	Citizen of What Country?
	with t	ā	14014 Marsh Pike	21742		USA
	filed within 72 hours after death with the Maryland Hygiene. Ither than "natural", or items 23a or 28a-f show ent, the Madical Examiner roust be notified at	by Funeral Directo			ecify Yes or No-	14. Race - American Indian,
	ter d	Fun	1 Never Married 2 Married 1 🖾 Yes 2 □ No	Was Decedent of Hispanic Origin? (Spi If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White, etc.
3	urs a		3 ☐ Widowed 4 ☑ Divorced If Yes, Give Year or Dates: 1952-54	1 ☐ Yes 2 🖾 No Specify:		Specify: white
2	2 ho	Completed	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of work	ing 16	6b. Kind of Business/Industry
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7	ad wil	Con	8 0 1abo			ity water dept.
2	be file tal Hy d oth	Be	17. Father's Name (First, Middle, Last)		e (First, Middle, Ma	iden Sumame)
Ž	Men Men arke	Ţ	Webster Smith	Edna S		
<u> </u>	2 sh 1 and 1 sm raum			ng Address (Street and Number or Run		
ນົ	1 and lealth		Charlene K. Lloyd-Comm.on Aging 140  20a. Method of Disposition 20b. Place of Dispo			own, Maryland 21740
2	or of		1 XBuriai 2 Cremation 3 Removal from State	matory or other place)		lintstone, Maryland
	it. Partmer rtmer rtant njury			p Vet. Cem. 1/25 2. Name and Address of Facility MIN		
Da	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene.  By any injury or other traumatic event, the Markleal Examinar must be notified at once.			415 E. Wilson Blvd		
i	1111		23a. Part1. Enter the disease, or complications that caused the death. Do not en			
	Dhuaisian		shock, or heart failure. List only one cause on each line.  Immediate Cause (Final	4		Onset and Death
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	Examiner		Candid Min	usalmy		
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying			
	cuted nd ransii	Examiner	Cause (Disease or injury that initiated events c.			
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200	attenc attenc for us	lan		□Ectopic pregnancy □ Other (specify)		23d. Date of delivery  Month Day Year
5	sician: The law requires that the death certificate has been signed by the attending rector, page 2 should be detached for use as	Physician/Me	1 Yes 2 No 9 Unknown	Other (specify)		
Ľ	that t ed by detai	/Ph	Part II. Other significant conditions contributing to death but not resulting in the u	underlying cause given in Part I.	23e. Did toba	acco use contribute to the cause of death?
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3	w req beer shou	Completed			24a. Was an	24b. Were autopsy findings available
ב ב	he la e has age 2	шc			autopsy	
A I La	an: T		25. Was case referred to medical	26. Place of Oeat	1 ☐ Yes 2 h (Check only one,	
>	ysicia s cer direct	To Be	examiner?  1 Yes 2 Hospital: 1 Inpatient 2 ER/Outpatie	Othon		ce 6 ☐Other (Specify)
5	g Ph er thi		27. Manner of Death 28a. Date of Injury 28b. Time of		28d. Describe how	
NISION NISION	ath.	atio	2 Accident investigation	M 1 ☐Yes 2 ☐No		
<u>"</u>	r Atte	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Stre City or Town,	eet and Number or Rural Route Number, State)
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	To the Hospital or Attending Physician: within 24 hours stafer death. To the Funeral Director: After this certifies completely filled in by the funeral director;	edical	29a. Certifier  (Check only (Check only (Check only and Check only (Check only	th occurred at the time, date and place, nvestigation, in my opinion, death occur	and due to the cau red at the time, dat	use(s) and manner as stated. ee and place, and due to the cause(s)
	the thin 2 the mplel	Med	one) and manner stated.  29b. Signature and title of certifier	29c. License number	296	d. Date signed (Month, Day, Year)
)	T W T		Fair miles			1/20/11
	V		30. Name and address of person who completed cause of death (Item 23a) (Type	Print)	18	
	VLT		FACID MV NS HED	1060396 Print) 1126 of al	stide	MO 21740
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature	142-924	/ / - /	
	Registr		JAN 2 0 2011 Jane A.	Dark!		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 0809 Winifred Hermine SADLER Janua Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Meritus Medical Center Hagerstown 9. Birthplace (State or Foreign Country) Jamaica West Indies If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, March 2, Social Security Number . Age (In yrs. last birthday) **Funeral** Min 1 □ M 2 🙀 F Hours 123-58-2995 75 Director March Usual Residence of Decedent show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director or 28a-f sh notified a 1X Yes 2 ☐ No Hagerstown Maryland Washington 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ò "natural", or items 23a o Funeral 21740 USA 673 Highland Way Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces Black, White, etc. δ 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify: Specify: black Completed 3 Widowed 4 X Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) police officer state government Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ivy Goulbourne Lawford Phillips 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 673 Highland Way, Hagerstown, Maryland 21740 Paulette Crockett - daughter 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1X Burial 2 Cremation 3 Removal from State Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Rose Hill Cemetery 1/ 28/2011 Signature of Funeral Service 22. Name and Address of Facility MINNICH FUNERAL HOME Hagerstown, Maryland E.Wilson Blvd., 415 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arres shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, Examiner ri any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) been signed by the should be detached g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has page 2 autopsy performe 1 ☐ Yes 2 ☐ Ne Yes 2 After this certificate within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 340 은 1 Despatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d, Describe how injury occurred Certificate: 1 HNatural 5 Pending 1 🗌 Yes 2 🗆 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OPAL CIT. HAGERSTOWN, MED 2174 9 122

State Registrar 31. Date filed (Month

1-00339 dam James Sauk		Department of Health and Mental H	
	1- For State Registrar	Certificate of Death	Reg. No.
Physician/ ledical Examine	Decedent's Name (First, Middle,Last)		2. Date of Death Month Day Year January 11, 2011  3. Time of Death 2045 hrs
	4a. Facility Name (if not institution, give street and number)  Johns Hopkins Hospital	4b. City, Town, or Location of Death Baltimore	4c. County of Death
Funeral Director	216 89 8038 1XM 2F	n yrs. last birthday)   If Under 1 Year   If Under 24Hrs   Months   Days   Hours   Min	Nov 13, 2010  8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Country) Marryland
und show any nce.	Maryland Anne Arundel	c. City, Town or Location Pasadena	10d. Inside City Limits 1 Yes 2 X No
with the Maryland ns 23a or 28a-f show be notified at once. aral Director	10e. Street and Number 7849 Centergate Court	10f. Zip Code 21122	10g. Citizen of What Country? United States
eath unst	11. Marital Status 1 Mever Married 2 Married Armed Forces?  3 Widowed 4 Divorced If Yes, Give Year or Date 5:	If Yes, specify Cuban, Mexican, Puerto  1 Yes 2 No specify:	Rican, etc.)  White, etc.  Specify: White
11215-0036 Id be filed within 72 hours after dental Hygiene. narked other than "natural", or event, the Medical Examiner mo. Be Completed by Fi	15. Decedent's Education (Specify only highest grade complete Elementary/Secondary (0-12)  College (1-4 or 5+)	ted) 16a. Decedent's Usual Occupation (Give kind of volume of during most of working life. DO NOT use reti	vork done red) 16b. Kind of Business/Industry n/a
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than c event, the Medica			(First, Middle, Maiden Surname)
MD 2121; d 2 should be fill Ith and Mental F n 27 is marked rumatic event, if	19a. Informant's Name/Relationship (Type, Print)  James Sauk (Father	19b. Mailing Address (Street and Number or 17849 Centergate Court, I	Rural Route Number, City or Town, State, Zip Code) Pasadena, MD 21122
Baltimore, MD 2's permit. Pages I and 2 should Department of Health and Mu Important: If item 27 is me injury or other traumantic error	20a. Method of Disposition     1 Burial 2 Cremation 3 Removal from State     4 Dogation 5 Other Specify:	Lee Crematory Jan 14, 2011	Date 20c. Location - City or Town, State  Clinton, MD
Baltil permit. Departm Importa	21. Suprature of Furiery Service Livensee	Ferry Road, Clinton, M	Funeral Home, Inc 6633 Old Alexandria  20735  Grespiratory gress, shock or heart Approximate Interval
Physician Medical Examiner	Milliodiate Cales (i milli disease	e death. Do not enter the mode of dying, such as cardiac of Le Injuries	Between Onset and Death
	or condition resulting in death)  Due to (or as a consequ  b.  b.  Due to (or as a consequ  b.  Due to (or as a consequ		
ted Insit	cause. Enter Underlying Cause (Disease or migry that initiated events resulting in death) Last  Due to (or as a consequence)		
execut an and al - tra	x UNPENDED AMENDED 23a	1,27,28a-f per me g918 8-20	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicia completely filled in by the funeral director, page 2 should be detached for use as the burnal chical Contributed by Diversirian/Medii	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown 9 Unknown 9 Unknown	2 Fetal death 3 Ectopic pregn	23d. Date of delivery  ancy Month Day Year
, P.O. B res that the d signed by the be detached		ut not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 Unknown
Records, The law require, freate has been sig., page 2 should be.			24a. Was an autopsy performed?  1 V Yes 2 No 1 Ves 2 No 2 No
Vital Rec ysician: The his certificate director, page	25. Was case referred to medical examiner?	26.Place of Death (Check 2 ER/Outpatient 3 DOA Other Nursi	only one) ng Home 5 Residence 6 Other:
ding Physical di	27 Manner of Death 28a Date of Injury	28b. Time of Injury 28c. Injury at Work?	28d. Describe how injury occurred
ttendin Heath. Hor: A	1 Natural 5 Pending 2 Accident Investigation fd 1-10-1	II fd 1:03am 1 Yes 2 X No	subject beaten 28f. Location (Street and Number or Rural Route Number, City
Division o spital or Attending sours after death. neral Director: Aft filled in by the func	3 Suicide 6 Could not be determined (Specify)	y - At home, farm, street, factory, office building, etc.  esidence	or Town, State) 7849 Centergate Ct. Pasadena. Md.
Division  To the Hospital or Attentwithin 24 hours after death  To the Funeral Director: completely filled in by the	4 X Homicide  29a. Certifier (Check only one)  2 W Medical Examiner: On the basis of examination of the desired forms of the desired fo	mowledge, death occurred at the time, date and place, an nation and/or investigation, in my opinion, death occurred	d due to the cause(s) and manner as stated.
F. W. W. P. D.	29b. Signature and title of certifier	29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year)  January 12, 2011
	30. Name and address of person who completed cause of dea Ana Rubio MD. Assistant Medical Examir	ith (Item 23a) ner 900 W. Baltimore Street, Baltimore, M	D 21223
Stat	0.00		

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Maryalice Northover Thomas 2:20 AM 2011 January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Silver Spring Montgomery Manor Care Silver Spring If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🖾 F Days Hours Min. (Month, Day, Year) 068-18-9771 89 **Director** City, MO February 6. Kansas Usual Residence of Decedent f shov 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 28a-f Silver Spring 1 X Yes 2 No Maryland Montgomery 10e, Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral items 23a 20904 TISA 2501 Musgrove Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 🖾 Yes 2 🗌 No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 K No Specify: Specify: White "natural" Completed 3 X Widowed 4 Divorced Year or Dates. 1942-1945 Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) AT&T Customer and Mental Hygiene, is marked other than College (1-4 or 5+) Elementary/Seconday (0-12) the Service Department Supervisor event. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) .. Page 1 and 2 should be fill tment of Health and Mental tant: If item 27 is marked o ည Ralph Light Northover Mary Maxon or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rosana C. Northover / Sister-in-law 3604 Varnum Street, Brentwood, MD 20722 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 a Department of H Important: If ite any injury or ot cemetery, crematory or other place) 1 

Burial 2 

Cremation 3 

Removal from State 1/20/2011 Alexandria, Virginia Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Gasch's Funeral Home, P.A. Hyattsville, MD 20781 RAY Rugers 23a. Part 1. Enter the dilease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Cardiopulmonary Arrest disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Cerebrovascular Accident Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine burial-transit Cause (Disease or linjury that initiated events Atherosclerosis Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ 23d. Date of delivery in the past 12 months? 1 Yes 2 g 2 🛛 No cate has been signed by the page 2 should be detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hypertension, End Stage Dementia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate l 1 Yes 2 No Yes 2 X No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 🛛 No ᅆ 1 Inpatient 2 ER/Outpatient 3 DOA After this 4 X Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death te Hospital or Attending Pl in 24 hours after death. The Funeral Director: After the pleted filled in by the funera 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) X Natural 5 Pending injury work?
1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, determined building, etc. (Specify) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated the within To the 29b. Signature and title of certifier 5 29d. Date signed (Month, Day, Year) 3 1/20/2011 R114730

State Registrar

Box 68760

P.O.

Records,

Division of Vital

Monica Immording, CRNP, 2501 Musgrove Road, Silver Spring, MD 20904

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

11-00544 Many Takei Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Mary Takei		l- For State Registrar	State	of Marylar		artment of rtificate of	f Health and f <i>Death</i>	d Mental		Reg. No. 2 ()	s spir ship and	03216
Physician Medical Examine	1/	1. Decedent's Name (F		) Takei					2. Date of De Month January	Day Ye	ar	3, Time of Death 1835 hrs
		4a. Facility Name (if no	ot institution, give	street and num	ber)		4b. City, Town, or Silver Spring			4c. County Montgo		
Funeral Director		5. Social Security Num	96 1		Age (In yrs. I	ast birthday) 75 <sub>Yrs</sub>	Months Days		A	irth(MM/DD/YYY 19, 1935		
d how any			ecedent b. County Montgome	ry	- "	Town or Locat						10d. Inside City Limits  1 Yes 2 XNo
the Marylan n or 28a-f sl	2	10e. Street and Number 15416 Bra	er	-		<u> </u>	10f. Zip Code 20906			10g. Citizen of W	hat Coun	itry?
	rune	11. Marital Status  1 Never Married  3 Widowed		12. Was Deced Armed Ford 1 Yes If Yes, Give Year or Dates:			es, specify Cuban	, Mexican, Pu	(Specify Yes or Nerto Rican, etc.)	Whi	e - Americ te, etc. Whit	e
136 thin 72 hours a te. than "natural edical Examin	Completed by	15. Decedent's Educ Elementary/Second 12					t's Usual Occupat ost of working life. aker			16b. Kind of B		ndustry
21215-0036 Muld be filed within 7 Mental Hygiene c event, the Medica	e n	17. Father's Name (Fir Peter Fa	rrell					Mary	eme (First, Middle, Christina	a Gill		
MD 21 nd 2 should alth and Me am 27 is ma aumatic co	Ĺ	19a. Informant's Name Brian Ch: 20a. Method of Dispos	ristophe			1615	Address (Stree Harbourt ition (Name of cen	on Roc	ktown Ro	imber, City or Tovad, Laπib	ertv	Zip Code) ille, NJ
Baltimore, permit. Pages I an Department of Hea Important: If itel injury or other tr		1 Burial 2 X	Cremation 3 Other Specify:		n State	crematory or oth tropoli		atory	Jan. 28 2011	Alexan		
	1	23a. Part I. Enter the o	new St	Cole	and the death	500	ancis J. Univers	Colling Bl	ns Funer	Silver S	Sprin	g, MD 20901
Physician Medical Examiner	1	failure. List only of Immediate Cause (Fin or condition resulting i	one cause on eanal disease a.		3		ie mode or dying,	Sucr as Cardio	or respiratory ar	Test, SHOCK, OF TR	iait i	Between Onset and Death
6		Sequentially list condi- if any, leading to imme- cause. Enter Underlyi (Disease or injury that events resulting in dea	ediate ( ring Cause t initiated c.	Oue to (or as a co								
50, te be executed yysician an	edical	UNPENDED	d	AMENDED								
ox 687(eath certifica eath certifica attending pheater for use as the	5 I	IF FEMALE: 3b. Was decedent pre past 12 months?  1 Yes 2 No		1 Live birt	it at time of de	2 Fe	tal death 3 [ ner (Specify)	Ectopic pre	gnancy	23d, Date o Month		ay Year
cords, P.O. B.  law requires that the de has been signed by the 2 should be detached i	2	Part II. Other significa	ant conditions	contributing to d	eath but not re	esulting in the u	nderlying cause g	iven in Part I.				he cause of death? ably 4  Unknown
Division of Vital Records, P.O. ral or Attending Physician: The law requires that the all Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach	Completed								1 Yes	psy orm <u>ed</u> ?		opsy findings available ompletion of cause of s 2 No
Physician: This certifial director	n i	25. Was case referred examiner?  1 ✓ Yes 2	The second second	ospital: 1Inp	patient 2	ER/Outpatient		of Death (Che	rsing Home 5	Residence 6	<b>✓</b> Other:	Scene
Division of Vital Rec To the Hospital or Attending Physician: The I within 24 hours after death. The I to the Functal Director: After this certificate I completely filled in by the funeral director, page		27. Manner of Death 1  Natural 5 2 ✓ Accident	Pending Investigation		ay,Year) )11	28b. Time of li FOUND: 1825 hrs	1 □ Y	y at Work? ′es 2 ✔ No	Probable fa			al Route Number, City
Divis  To the Hospital or A within 24 hours after To the Funeral Direct Completely filled in the		3 Suicide 6 4 Homicide 29a. Certifier	Could not be determined	(Specify)	Single Fam	nily Home	et, factory, office b		or Town,	State) ble Wood Drive	e, Silver	Spring, MD
To the Hospital within 24 hours To the Funeral completely filled		one) 2 Me	edical Examiner		examination a	_	ion, in my opinion,	death occurre	ed at the time, date		due to the	e cause(s)
12		29b. Signature and title	` `				29c. License			January 2		
		30. Name and address Ana Rubio MD	•	•	-		more Street,	Baltimore,	MD 21223			
Stat	e	31. Date filed (Month, i	Day, Year)	32. Regi	strar's Signatu	ire have						<del>-</del>

OCME

Amend #1 per Phy 1/19/2011 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AA co. Health Dept. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death () 232 M Margaret Pose Testa aka Michelin Physician/ Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death County of Death Anne Arundel HeartHomes at Piney Orchard Odenton If Under 1 Year If Under 24 Hrs. **Funeral** Social Security Number 6. Sex Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 L Months Days Hours August 24,191 New York **Director** 099-09-6680 97 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Crofton MD Anne Arundel 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1722 Urby Drive 21114 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married ρ 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: 3 X Widowed 4 ☐ Divorced White Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) 2 should be filed within 72 ! h and Mental Hygiene, 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) 10 Data Processor Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev Carlo Sutera Maria Santangelo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan Schertzer/Daughter 1722 Urby Drive, Crofton, MD 21114 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Metro Crematory 1/18/2011 4 Donation 5 Other (Specify) Baltimore, Maryland 21. Signature of Furriral Service License 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy., Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cach, on each line. Approximate Interval Between Immediate Cause (Final Physician/ MEN disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed nding physician and use as the burial-transi Cause (Disease of imputhat initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 🗌 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 🗌 Yes 2 No 은 4 Nursing Home SSISSIE 1 Inpatient 2 ER/Outpatient 3 IDOA 5 Residence 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred LIVING 1 Natural 5 Pending injury after death. 1 Yes 2 No 2 Accident
3 Suicide Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) 24 hours a Funeral I Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. соmpleted Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within To the License number D 20 completed cause of death (Item 23a) (Type, Print GHTFOOT-TAYLOR egistrar's Signature State 1 9 2011 Registrar

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death CHARLES RODNEY TAYLOR JAN. 16, 12:48PM 2011 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death DORCHESTER CAMBRIDGE DORCHESTER GENERAL HOSPITAL If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Months Days 66 217-42-1746 MARYLAND FEB. 15,1944 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 □Yes XXNo CHARLES INDIAN HEAD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? UNITED STATES 20640 6224 FORD DRIVE 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2XXXIo Specify: BLACK Specify 3 X Midowed 4 ☐ Divorced Year or Dates: 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) FEDERAL GOVERNMENT Elementary/Secondary (0-12) College (1-4or 5+) 12TH CONSTRUCTION MANAGER U.S. CENSUS BUREAU 2+ YEARS 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) CHARLES ANTHONY TAYLOR EDITH VIOLA WATERS TAYLOR 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. BOX 176, COBB ISLAND, MD 20625 DARRYL ANTHONY TAYLOR /son 26, 20b. Place of Disposition (Name of Centerly, crematory, or other place) MARYLAND VETERANS CEMETERY 201 20c. Location - City or Town, State 20a. Method of Disposition 1XXeurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) CHELTENHAM, MD 2011 METER: 22. Name and Address of Facility TERRENCE L. JOHNSON FUNERAL SERVICE TERRENCE L. JOHNSON FUNERAL SERVICE TANE. WHITE PLAINS 21. Signature of Funeral Service Ligencee TERRENCE L. JOHNSON FUNITERRENCE L. JOHNSON FUNITERREN Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) HTHEROSCLEROTIC CARDIO VASCULAR DISEASE Due to (or as a consequence of): HISTORY CEREBRAL OF Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: yes, outcome of pregnancy ☐ Live birth 2 ☐ Fetal death ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 No Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 2 **1** No 1 ☐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No

**Physician** /Medical Examiner

death certificate be executed

Box 68760.

P.0.

Division of Vital Records,

or Attending Physician:

Hospital 24 hours a

**Physician** 

/Medical

10a State

MD

Examiner

**Funeral** 

Director

28a-f show

Director

Funeral

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Completed

in than "natural", or items 23a or 28a-f show

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Pages 1 permit. Pages Department of Important: If Its any injury or o

death

within 72 hours after

Baltimore, Maryland 21215-0036

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Examiner attending signed by the peen cate has b certificate this After thi funeral death illed in by the f

Physician/Medical þ Completed Be 27. Manner of Death

Medical

1 Natural 2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

Certification: To

TRB8+

DHMH 17 Rev 1/2001

within 2

State Registrar 29b. Signature and title of certifie 30. Name and address of p

5 Pending investigation

6 ☐ Could not be

determined

MD.

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

29c. License number D69234

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

2011

28f. Location (Street and Number or Rural Route Number, City or Town, State)

rson who completed cause of death (Item 23a) (Type, Print)

ERRABOLU JEEVAN BYRN ST 503

CAMBRIDGE

28d. Describe how injury occurred

32. Registrar's Signature

28a. Date of Injury (Month, Day, Year)

and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3 Time of Death January Physician/ 201 Teal  $23^{ay}$ 12:16 a.M Toney Wakefield Robert Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Fort Washington Hospital Fort Washington If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🕱 M 2 🗆 F Months Hours 01/31/1932 Director 78 Washington, DC 577-40-8875 Usual Residence of Decedent or 28a-f show notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Department of Health and Mental Hygiene.
Important: If item 27 is marked of ther than "natural", or items 23a or 28a-f sho may injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2XXNo Charlotte Hall Maryland Charles 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7525 Poplar Street 20622 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?
1 

Yes 2 □ No Black, White, etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 White 1 Yes 2 No Specify: 3 X Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Building Contractor Construction Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Unknown Myers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tracy Pearson/ Daughter <u>7525 Poplar Street, Charlotte Hall, MD 20622</u> Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Brinsfield-Echols 01/25/2011 4 ☐ Donation 5 ☐ Other (Specify) Charlotte Hall, MD . Signature of Funeral Service License 22. Name and Address of Facility Brinsfield-Echols Funeral Home, P.A. P.O. Box 128, Charlotte Hall, MD 20622 22a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph\_sician/ congestive hear disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** schemi Sequentially list conditions. Examiner n any, reading to immediate cause. Enter Underlying Cause (Disease or iinjury After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit arterio Hospital or Attending Physician: The law requires that the death certificate be executed Sclen that initiated events resulting in death) Last Due to (or as a consequence of) by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Day Pregnant at time of death 5 Other (specify) 4 ☐ Pregnant : 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 KNo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 N 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? filled in by the funeral director, 26. Place of Death (Check only one) Be Hospital Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) Other (Specify) 2 No မ 1 🔲 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred (Month, Day, Year) ✓ Natural 5 Pending iniury death. 2 Accident
3 Suicide
4 Homicide Investigation 24 hours after deat Funeral Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated \_\_\_\_\_\_ Cartiyins, Nurse Frontiener To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated \_\_\_\_\_\_ Cartiyins, Nurse Frontiener To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated \_\_\_\_\_\_ Cartiyins. To the land within 2 inly unel 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month. Dav. Year) NO D0005569 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 7/2009

van

31. Date filed (Month, Day, Year)

MD

Registrar's Signature

Fort Washington, MD 20744

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State	of Marylan		artment of H tificate of D		Mental Hy	giene Reg. No.2 Ü	P. Carrier	03220	
	Discontinuing	,	1. Decedent's Name (First, Middle	, Last)					2. Date of De Month		Voor	3. Time of Death	
	Physicia Medic		Kenneth	Ralph	Turner				Januar	y 21, 2	2011	3:00 p. <sup>M</sup>	
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	Funeral								8. Date of Bir (Month, Da 08/04/		9. Birth	place (State or Foreign	
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Baltimore, Maryland 21215-0036	permit. Page Department ( Important: If any injury or once,		21. Signature of Funeral Service L	icensee / 2		22 R-	Name and Addres	s of Facility	Funeral	Home	РΔ		
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2	To the Hospital or Attending Physician: The la within 24 hours after death.  To the Funeral Director: After this certificate he completed filled in by the funeral director, page			Bullo	ing, etc. (opecny,	<b>,</b>			City of 10V	m, State)			
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,			30. Name and address of person	who completed car	ise of death (Item	23a) (Type P		01760		1 2	7 2		
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DHMH 17 Rev 7/2009

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	eral		5. Social Security Number 215–03–5114	6. 3	Sex 7 1 □ M 2 <b>∑</b> F		last birthday, Yrs.	Months	r 1 Year Days	If Under Hours	Min.	8. Date of (Month	, Day,			Count	27	or Foreign
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all y shou and N small	uma		19a. Informant's Name/Rel	ationship	(Type. Print)		19b. Maili	ng Addres	s (Street	and Numbe	er or Ru	ral Route Nu	ımber,	City or 7	Town, Sta	te, Zip	Code)	
and 2	m 27 is her tra		Edward O. Uli	rich,	Jr./Son		_			Rd.		anton,			1561			
Dailiniole, Mal ylallo 212.13-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show	or of		20a. Method of Disposition 1 ☐ Burial 2 ☑ Crema	ation 3 E	Removal from Sta	0	Place of Disponentery, cre	matory or	other plac			Date			ation - City			D.7
it. Pa	njury .		4 □ Donation 5 □ Ott		· · · · · · · · · · · · · · · · · · ·	Cou	intry S										ville	PA
Depa Depa Impo	any Ir		21. Signature of Funeral Se	- Lice	nsee	)						wman E tsvill			2153		P.A.	
			23a. Part 1. Enter the disea	se, or con	plications that caus	ed the deatl							-				Approxima Interval Be	
Physic	cian		shock, of heart failure Immediate Cause (Final disease or condition	. List only	one cause on each	i line.	0	1.011	ilm.	Longe		10-	15	_			Onset and	
→ /Med	lical		resulting in death)		Due to (or	as a consequ	uence of):	resp	MAL	1019	10	feer	70-7				, 4-6	
Exami	iner	_	Sequentially list conditions, if any, leading to immediate		b											_		
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<b>r,</b> executed n and	al-tra	Exar	that initiated events resulting in death) Last		c Due to (or a	as a consequ	uence of):									-		
eath certificate be executed attending physician and	e pri	cal																
ortifica ing ph	as th	Physician/Medical	IF FEMALE:													_		
ath ce	or use	ian/l	23b. Was decedent pregna in the past 12 months		23c. If yes, outcon 1 ☐ Live birth	n 2 ☐ Feta	I death 3	☐ Ectopic		у				23	d. Date of Month		-	Year
the de	shed f	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown		4 ☐ Pregnan 9 ☐ Unknow		death 5	Other (s	specify) _				_				,	
res that the de signed by the a	detac		Part II. Other significant co	onditions	contributing to death	but not resi	ulting in the ι	ınderlying	cause giv	en in Part I		23e. [	Did toba	acco use	contribu	te to th	e cause of	death?
quires an sign	ed blu	sq ps	Coagestiva	hea	it fail	ene,	ger	ere	mu	Stil	Dil	1	☐Yes	2 🗆	No 3	Prob	ably 4	Unknown
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The The	page	Completed		, , , ,									erform		deat	th?	2 □ No	badse of
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ding Physician: The h. After this certificate h.	ral din	<u>٩</u>	1 Yes 2 No 27. Manner of Death		Hospital: 1 Inpa		ER/Outpatie			4 DALINI	ursing H	ome 5 F				Specify	()	
Affer Affer	fune	tion	1 Natural 5 ☐ F	ending ovestigatio	(Month, i	Day, Year)	Injury	" м	28c. Injur Worl	k? Yes 2□	No	Zod. Desci	ID <del>C</del> HOV	v mjury i	occurred			
Atten r deat	by the	ifica	3 ☐ Suicide 6 ☐ C	Could not b	e 28e. Place of	Injury - At ho	ome, farm, st	reet, facto							Number o	r Rura	l Route Nui	nber,
tal or safte	eqin	Certification:	4 🗆 Hornicige		building,	etc. '(Specif	у)					City of	Town,	State)				
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicis	tely fill	ical	(Check only 2☐ Me		hysician: To the be miner: On the basis	of examina												s)
the ithin 2	эшре	Medical	one)  29b. Signature and title of c	ertifier	and manner	stated.		25	c. Licens	e number			29	d. Date	signed (N	fonth, i	Day, Year)	
F ≥ 5	ŏ		MALLA	of1	Kain	M				1266	050			1	/19	10	211	
			30. Name and address of p	erson who	completed cause o	f death (Item	n 23a) (Type,	Print)					Ш					
		12	margaretak	aise	RND	13079	n 23a) (Type, dure) hture	et hu	Sens	ray	00	Klar	d,	Ma	21:	550	0	
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Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink, Ensure Allicopies Are Legible.

Amend 23a per med cert
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Mina VAL Ja<u>nuarv</u> 2011 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Rockville <u>Jefferson St.,</u> If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🔯 F Months Days Hours Min. Romania 578-18-9174 **Director** Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f shov event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director Rockville Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20852 1801 E. Jefferson St., #202 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 Nidowed 4 □ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Je filed with... ⁴al Hygiene. `ar than "r (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed withir.
Department of Health and Mental Hygiene.
Important: If item 27 is marked other tha
any injury or other traumatic event, the h
once. Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Yehoshua Khuvis Ita Batya (unknown) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3714 Livingston St., NW, Washington, DC Leah Bendavid-Val, Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 🕅 Burial 2 🗆 Cremation 3 🗀 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 01/24/2011 Adelphi, MD Lebanon Cemetery 22. Name and Address of Facility
Torchinsky Hebrew Funeral Home 21. Signature of Funeral Service Licensee Carrell St., NW, Washington, DC mode of dying, such as cardiac or respiratory arrest. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ allyse disease or condition Medical resulting in death) Examiner Dementia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury e attending physician and Due to (or as a consequence of): that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) Month signed by the a 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy Director: After this certificate Yes To the Hospital or Attending Physician: within 24 hours after death. within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5  $\square$  Pending injury 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 5 D69568 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) street Rockville, MD 20852 Chilakamaso E Jefferson

РМ

11:25

9. Birthplace (State or Foreign

white

20012 Approximate Interval Between Onset and Death

Year

Day

2 🗌 No

10d. Inside City Limits

1 Yes 2 □ No

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

JAN 24

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ JANUARY 2011 2100 РМ JOHNNIE L. WILLIAMS Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner MONTGOMERY HOLY CROSS HOSPITAL SILVER SPRING 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** FLOKIDA 1 🙀 M 2 🗆 F Davs Hours Min. DECEMBER 28 Months 62 1948 183-36-9997 Director Usual Residence of Decedent items 23a or 28a-f show her must be notified at 10b. County 10d. Inside City Limits 10a. State 10c. City. Town or Location within 72 hours after death with the Maryland Director 1 X Yes 2 No M MONTGOMERY SILVER SPRING 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? Funeral 20910 603 SLIGO AVENUE, #515 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. 11, Marital Status 12. Was Decedent Ever in U.S. Armed Force If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc ō ģ 1 Never Married 2 Married 2 K No Yes Maryland 21215-0036 Specify: BLACK 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates "natural" Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) PRIVATE THEOLOGY 4+ ge 1 and 2 should be filed wit nt of Heatth and Mental Hygie t: If item 27 is marked other or other traumatic event, ti Be 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ JOHNNIE WILLIAMS CATHERINE MCDUFFIE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1985 SHANNON CREEK RD., GOODSPRING, TENNESSEE 38460 CATHERINE HICKS - MOTHER 3altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 Department of Important: If it any injury or or cemetery, crematory or other place) 1 

☐ Burlal 2 ☐ Cremation 3 ☐ Removal from State 01/24/2011 SUITLAND, MARYLAND WASHINGTON NATL CEMETERY 4 Donation 5 Other (Specify) 22. Name and Address of Facility JOHNSON & JENKINS FUNERAL HOME 21. Signature Funeral Service License 20011 716 KENNEDY STREET, NW, WASHINGTON, DC 23a. Part 1. Enter the disease, or combilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ CARDIAC ARREST disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner ACUTE RESPIRATORY FAILURE Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events SEVERE RECALCITRANT ASCITES The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical METASTATIC COLON CANCER Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d, Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Day Year Month signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown peen s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? Yes 2 ₺ No this certificate | 1 ☐ Yes 2X No or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2X No 1 🗌 Yes ER/Outpatient 3 DOA Certificate: To 1 🗓 Inpatient 2 🗆 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital o within 24 hours af To the Funeral Di Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 2 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature ar d tile of certifie 29c. License number 29d. Date signed (Month, Day, Year) 01/17/2011 D67589 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD, 1500 FOREST GLEN ROAD, SILVER SPRING, MARYLAND 20910 HAROLD V. LAWSON, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ - Month 35.0M JAMES WELLS JANUAR Α. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death PRINCE GEORGE'S DOCTORS HOSPITAL LANHAM 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. g. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 1 🛛 M 2 🗆 F Months Days Hours nth, Day, Yrs ALABAMA Director 89 TUNE 419-16-2448 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No PRINCE GEORGE'S BOWIE MD 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be n Funeral USA 16300 ARGENT COURT 20716 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ıral", or iten I Examiner r 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 X Yes 2 □ No ARMY If Yes, Give Year or Dates. 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. Item 27 is marked other than "natural", or Maryland 21215-0036 BLACK 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Specify. Completed 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12th College (1-4 or 5+) PRIVATE INSTRUCTOR Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 JAMES WELLS BESSIE TYSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar important: If Item 27 is any injury or other trau once. 210 KENDLE STREET UPPER MARLBORO, MARYLAND 20774 GLADYS WELLS HEATLEY/DGT Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Crem ☐ Donation 5 ☐ Other (Specify) CREMATORY 1/24/2011 RIVERDALE, MARYLAND Signature of Funer vice Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. ROAD HYATTSVILLE, MARYLAND LANDOVER 23a. Part 1. Enter samplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arr Approximate Interval Between Onset and Death rant 1. Enter the disease, or semplication shock, or heart failure. List only one caus Immediate Cause (Final Start Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Exami the attending physician and hed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): cal Division of Vital Records, P.O. Box 68760 Physician/Medi IF FEMALE: es, outcome of pregnancy
Live Birth 2 D Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Day Year Unknown Unknown þ contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has performed To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director; After this certificate P 2**₹** No Yes 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 2 X No Other: 1 Tyes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of iniun 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 1 4 Homicide determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie (Check only one) 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar

State

who completed cause of death (Item 23a) (Type, Print)

mD.

MAD 3152

16128 handover Rd.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Day 13,201 Peggy J. Wingert Vanuar Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Lanham Doctor's Community Hospital 8. Date of Birth 9. Birthplace (State or Fore Country)
Jan. 13, 1949 Pennsylvania Social Security Number . Age (In yrs. last birthday) 6. Sex If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🖾 F Min. Hours 62 Director 167-38-6975 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location Director or 28a-f st notified a 1 Yes 2 X No Prince George's Lanham MD 10e. Street and Number 10g. Citizen of What Country? ō 10f. Zip Code Important: If Item 27 is marked other than "natural", or items 23a o any injury or other traumatic event, the Medical Examiner must be Funeral permit. Page 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. 20706 USA 9215 Roxanne Dr. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 X Married 1 Yes : 2 X No 1 ☐ Yes 2X No Specify: Specify: White 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry Baltimore, Maryland 21215 (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Federal Government Social Security Administration Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Albert Thomas Jean Pegg 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Terrance M. Wingert / Spouse 9215 Roxanne Dr., Lanham, MD 20706 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 

Burial 2 

Cremation 3 

Removal from State 1/15/2011 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Beall Funeral Home <u>6512 NW Crain</u> Bowie, MD 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lailure. List enty one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. attending physician and for use as the burial-transit Cause (Disease or finjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Year To the Funeral Director: After this certificate has been signed by the a completed filled in by the funeral director, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an PNEUMONIA death? 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 2 No Other: မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined within 24 hours a

To the Funeral Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Fractioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GOOD LUCK POAD LAUMAM, MD 20706

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ 20<sup>Year</sup> 5:38 P M January Medical 4b. City, Town, or Location of Death Solomons 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner Solomons Nursing Center Calvert County 8. Date of Birth (Month, Day, ) April 29 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Age (In yrs. last birthday) **Funeral** Days Hours 1 M 2 X F 95 Maryland 579-12-6954 Director Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland al Hygiene. 10a State Director 1 🗆 Yes 2 🏲 No Maryland Calvert County Solomons 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 20688 United States 3325 Dowell Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces Black, White, etc. 1 Never Married 2 Married þ Yes 2 X No Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: If Yes. Give Specify: 3 XWidowed 4 Divorced Completed Year or Dates. 16a. Decedent's Usual Occupation 15 Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) should be filed within 72 and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) At Home Homemaker event. Be 18. Mother's Name (First, Middle, Maiden Surname)
Agnes S. Wood 17. Father's Name (First, Middle, Last) 2 Peter G. Herbert permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic o traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Peggy Collier/Daughter Farm Pond Lane, Martinsburg, WV 25404 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ▼Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Old Fields Cemetery 1-22-2011 Hughesville, MD 22. Name and Address of Facility Brinsfield-Echols F.H., P.A., of Funeral Seprice Licens 30195 Three Notch Rd., Charlotte Hall, MD 20622 M00817 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician. disease or condition Medical resulting in death) consequence of Examiner Esque tally list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be eximinin 24 hours after death. Within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending nhysicia Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav Year Pregnant at time of death 5 Other (specify) signed by the sid be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page 2 performed 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) director, Be examiner's Hospital: Other: 20 No 1 Inpatient 2 ER/Outpatient 3 DOA 1 🗌 Yes ျှ 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) the funeral Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural injury 5 Pending 1 Yes 2 🗆 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Medical Ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29d. Date signed (Month, Day, Year) 29b. Signature and title of 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Dr. Blattau, 110 Hospital Drive, Suite 310, Prince Frederick, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

			State of Maryland / Department of Health and N		_	э.
			1 - Registrar  Certificate of Death		Reg. No.	1 00007
			negistrar  1. Decedent's Name (First, Middle, Last)	2. Date of De	ath	3. Time of Death
	Physici		Rena Wilt	Month 01	23 2011	4:25a M
	/Medio Examir		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death		4c. County of E	Death
and I			Garrett County Memorial Hospital Oakland		Garr	
	Funeral		5. Social Security Number 6. Sex 1	8. Date of Bird (Month, Da		Birthplace (State or Foreign Country)
	Director		Usual Residence of Decedent	05 07	1929	Maryland
	ylanc how		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	aa-f s	cto	MD Garrett Oakland			1 □Yes 2 No
	72 hours after death with the Maryland 'natural", or items 23a or 28a-f show digal Expression and benefited at	Director	10e. Street and Number 10f. Zip Code		10g. Citizen of Wha	t Country?
	s 23a	eral	415 Truesdale Road 21550	17 17 11	USA	
	item item	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 Never Married 2 Married  12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, specify Cuban, Mexican, Puerto	ecity Yes or No Rican, etc.)	- 14. Race - / Black, V	American Indian, Vhite, etc.
036	urs af	by	3 ☑ Widowed 4 ☐ Divorced   If Yes, Give   1 ☐ Yes 2 ☑ No Specify:		Specify:	White
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ä	e d al	B B			Maiden Surname)	
Maryland 2121	2 should be to and Mental is marked o raumatic eve	ဥ	Levi Bittinger  Armeda B  19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or Run.			te. Zin Code)
	s 1 and 2 should f Health and Men item 27 is marke other traumatic		Brenda Stone-daughter 75 Table Rock Road, Oa		-	te, zip dede)
ē,	s 1 and 2 of Health item 27 i		20a. Method of Disposition 20b. Place of Disposition (Name of	Date	20c. Location - City	or Town, State
Ë	e = = 5		Test Burlar 2 Dicternation 3 Directioval from State	/2011	Deer Park	, Maryland
Baltimore,	permit. Page Departmen Important: any injury once.		21. Signature of Juneral Service Licensee 22. Name and Address of Facility Dav			
n —	99 E 29		Ward A Durdowk 21 N 2nd St., Oaklas	nd, MD	21550	
			23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac ships, or heart failure. List only one cause on each line.	or respiratory a	rrest,	Approximate Interval Between
ing.	Physician		Immediate Cause (Final disease or condition  a. Quite Congestive hear	et ta	ilure	Onset and Death
4	/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)  a.   Quite Congestive had Due to (or as a consequence of):  Sequentially list conditions,  b.   Sequentially list conditions,	2		
		e.	Sequentially list conditions, if any, leading to immediate  b. Due to (or as a consequence of):	<u> </u>		
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury			
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3/60,	To the Prospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.	ical	d			
200	ertifica ling ph e as th	Physician/Medi	IF FEMALE:			
ŏ	ath c	ian/	23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy  1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy		23d. Date of Month	fdelivery Day Year
	he de the s	ysic	1 Yes 25No 4 Pregnant at time of death 5 Other (specify) 9 Unknown			
Τ.	that t		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did t	obacco use contribu	te to the cause of death?
ecords	quires n sigr ald be	d by	unphyserna, dialetics type II	119	Yes 2∏No 3[	Probably 4 Unknown
ပ္ပ	sw rec s bee	lete		24a. Was		e autopsy findings available
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> i	hysic his ce Il dire	၉		me 5 ☐ Resi	dence 6 ☐Other (	Specify)
בס ס	ing P	ë	1 Matural 5 Pending (Month, Day, Year) Injury Work?	28d. Describe I	now injury occurred	
VISIC	ttend death tor: / the f	cat	Accident investigation M 1 Yes 2 No 3 Suicide 6 Could not be	004  +i (	0	0.10.44
<u> </u>	or A after Direc in by	Certification:	Suicide 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	City or Tox		or Rural Route Number,
-	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  Within 24 hours after death.  The Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the team.		29a. Certifier Physician: To the best of my knowledge, death occurred at the time, date and place,	and due to the	cause(s) and mann	er as stated.
:	n 24 h	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurrence) and manner stated.			
1	Vithi To the	M	29b. Signature and title of certifier 29c. License number		29d. Date signed (M	fonth, Day, Year)
			Mangaret a fam 10 D 26650		1/24/	2011
		10	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	. 01	) 1	1 \
	-01		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Margaret a Kaiser my (3079 garret) highway  31. Date filed (Month, Day, Year)  32. Registrar's Signature	Oakl	and Mo	4 21550
	Sta Registr		JAN 2 5 2011 A Level		,	
			Commo je. pp			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January  $1^{Day}$ 201T 6:50 Edward Daniel Wachter, Sr. Ам Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Northampton Manor Nursing Home Frederick Frederick If Under 1 Year If Under 24 Hrs. g. Birthplace (State or Foreign Funeral Social Security Number 6. Sex Age (In yrs. last birthday) 8. Date of Birth July 17, 1 X M 2 □ F Days 1922 Maryland Director 88 220-18-1992 Usual Residence of Decedent shov Page 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Direct 1 Yes 2 X No Frederick Maryland Frederick 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 7561 Sundays Lane 21702 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 14 Race - American Indian Black, White, etc. 1 Never Married 2 Married þ 1 Yes If Yes, Give 2 X No Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White Specify: 3 K Widowed 4 □ Divorced Completed Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Montgomery County d Mental Hygiene. marked other than ' Boiler Elementary/Seconday (0-12) College (1-4 or 5+) Public Schools 12 Plumber Mechanic or other traumatic event, Be 17. Father's Name (First, Middle, Last) (unk.) 18. Mother's Name (First, Middle, Maiden Surname) ည Jennie Rice 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jack Wachter / Son 865 Shanghai Rd., Berkeley Springs, WV 25411 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot Jan. Date 7, 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State Resthaven Crematory Frederick, Maryland 4 Donation 5 Other (Specify) 2011 21. Signature of Fund Servic Licensee Resthaven Funeral Services, Skkot Cody P.A. 9501 Catoctin Mountain Hwy. Frederick, MD 21701 23a. Part 1. Enter the disease, or shock, or heart failure. List diseas, or co concations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, allurer List any one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or ndition resulting in death) METASTATIC Physician/ Medical Due to (or as a consequence of): **Examiner** U Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examir burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): ending physician use as the burial Physician/Medical The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? signed by the atte d be detached for Month Day Year g 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Tes or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 Tes 2 📈 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Watural 5 Pending within 24 hours after death.

To the Funeral Director A completed filled in by the fu r death. Accident 1 🗌 Yes 2 🗌 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital Medical Lertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier License numbe 29d. Date signed (Month, Day, Year) 01-17-2011 WO 5 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FREDERICK MM 21701 HOUSE AVE 814 loll KAZMI MM 31. Date filed (Month. 32. Registrar's Signature

State

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month January 23, 2011 4:50 Larry LoraineWilhelm Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Lonaconing 15817 Old Beechwood Road Allegany Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex **Funeral** Country) Maryland (Month, Day, Year) August 04, 1935 Days 1 📈 M 2 🗆 F Hours Min. Yrs Director 220-32-4673 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must ha material and injury or other traumatic event, the Medical Examinar must ha material and injury or other traumatic event, the Medical Examinar must ha material and injury or other traumatic event. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 No Lonaconing Maryland Allegany 10e, Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 21539 USA 15817 Old Beechwood Road 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 X Yes 2 No f Yes, Give Black, White, etc. 1 Never Married 2 M Married ģ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: Completed 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Grocery Butcher Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Scott Olin Wilhelm Laura Ellen Durst 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15817 Old Beechwood Road, Lonaconing, Maryland, 21539 Gladys Louise Wilhelm - Wife 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State January 26 St. Ann's Cemetery Avilton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2011 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Eichhorn-McKenzie Funeral Home P.A Lonaconing, MD 21539 8 East Main Street 23a. Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical nce of Examiner Sequentially list conditions. Examine cause. Enter Underlying Due to (or as a consequence of). by the attending physician and stached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death Other (specify) page 2 should be detached ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? been signed ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed this certificate 1 Yes 2 No Yes 2 2 eral Director After this certific filled i by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 10 Hospital: Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending Natural 1 Yes 2 No 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number 4 Homicide determined within 24 hours a er To the Funeral Dire building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number

State Registrar 23a) (Type, Print)

30. Name and address of person who completed cause of death (its

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# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State of Maryland / D	•	and Mental Hy	giene	00000		
			Registrar	Certificate of Death		Reg. No.	13/31		
	Physicia	n/	1. Decedent's Name (First, Middle, Last)		2. Date of Dea Jan. 16		3. Time of Death 06:50 A M		
	Medic		Harold Clay Yarn  4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location		4c. County of Deat			
	Examin	er		The state of the s	nton		Prince George's		
	Farmer		Southern Maryland Hospital  5. Social Security Number   6. Sex   7. Age (In yrs. last birtho			rth 9. Birthplace (State or Foreign			
	Funeral Director		1 XM 2 🗆 🗆	rs. Months Days Hours	Min. (Month, Day Oct. 2	(, Year) Co	<sup>untry)</sup> Florida		
			Usual Residence of Decedent		1000. 2	, <u>, , , , , , , , , , , , , , , , , , </u>	1401144		
	and sho	io	10a. State 10b. County 10c. City, Town of	or Location			10d. Inside City Limits		
	Mary 28a-f stifie	9	Maryland Prince George's	Upper Mar1b	oro		1 🔀 Yes 2 🗌 No		
	the or 2	澶│	10e. Street and Number	10f. Zip Code		10g. Citizen of What Co	ountry?		
	with s 23% ust b	Funeral Director	8409 Grandhaven Avenue	20772		United	States		
	leath item ier m	ᆵ	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Original of Market State (1988) 13. Was Decedent of Hispanic Original Ori	gin? (Specify Yes or No-	14. Race - Ame Black, Whit			
S	be filed within 72 hours after death with the Maryland ental Hygiene. Wed other than "natural", or items 23a or 28a-f show feed other than "natural", or items 23a or 28a-f show ic event, the Medical Examiner must be notified at	Completed by	1 Never Married '2 Married 1 X Yes 2 No	1 ☐ Yes 2 🖾 No Specify:		Specify: Afr			
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Maryland 21215-0036	should be file h and Mental 7 is marked o traumatic eve	욘	Clifford Clay Yarn		Jennie H	Bryant			
a Z	bluor Ind M S ma S ma umat	ı	19a. Informant's Name/Relationship (Type, Print) 19b. I	Mailing Address (Street and Number	er or Rural Route Number	; City or Town, State, Zi	p Code) 20772		
Ξ	d 2 sl alth a alth a 27 i		Jenole Yarn - Daughter 84	09 Grandhaven Av	venue Upper	Marlboro,	Maryland		
ē.	permit. Page 1 and 2 should be 1 Department of Heath and Menta Important: If item 27 is marked any injury or other traumatic er once.		20a. Method of Disposition 20b. Place of Disposition	Disposition (Name of	Date	20c. Location - City or	Town, State		
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Baltimore,	permit. Departr Importa any inju		21. Signature of Funeral Service Licensee	22. Name and Address of Facilit	ty Stewart Fu				
מ	99 = F 9		MATTER JOHN TO THE MALL	4001 Benning Ro	oad NE Wash	nington, DC	20019		
			23a. Part if Sinter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	t enter the mode of dying, such as	cardiac or respiratory arr	est,	Approximate Interval Between		
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2/0	mcate ig phy as th	Med	UE FEMALE.						
200	endin use	an/I	F FEMALE: 23b. Was decedent pregnant   23c. If yes, outcome of pregnancy   1	3 Ectopic pregnancy		23d. Date of de			
go.	death he att ed for	Physician/Me	in the past 12 months?  1   Yes   2   No   4   Pregnant at time of death   9   Unknown   9   Unknown	5 Other (specify)		Month	Day Year		
7. Ö.	at the d by t etach		Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part	l. 23e Did to	bacco use contribute to	the cause of death?		
νς. Σ	res tha signer	Completed by	corunary artem bypas				Probably 4 Unknown		
ğ	requi	ete		0	24a. Was	an 24h Were au	topsy findings available		
or Vital Records,	e law e has ge 2 s	mp			autor perfo	prior to med?	completion of cause of		
ř i	n: Ih ficate or, pa		25. Was case referred to medical	26 Plans of Dog	1  Yes	2 No 1 Ye	s 2 No		
2	sicia certi irecto	Be c	examiner?	Othor		а Пон и	· · ·		
<u> </u>	Phy r this eral d	<u>€</u>	27. Manner of Death 28a. Date of injury 28b. Tir	me of 28c. Injury at	ursing Home 5 Resid	ow injury occurred	oity)		
֓֞֞֝֟֜֝֝֞֜֝֝֟֝֝֟֝֝֟֝	nding tth. : Afte e fune	cat	1	ury work? M 1 ☐ Yes 2 ☐					
DIVISION	Atter	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm building, etc. (Specify)	n, street, factory, office	28f. Location (S City or Tow	treet and Number or Ru	ural Route Number,		
≥ :	rsafturalor		building, etc. (Specify)		City of 10w	n, state)	0		
	to the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  within 24 hours after death.  completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, de (Check 2 Medical Examiner: On the basis of examination and/or in the basis of my knowledge, de	investigation, in my opinion, death or	ccurred at the time, date a	nd place, and due to the	cause(s) and manner stated.		
	the thin 2 the much the thin 2 the land	Me	only one) 3  Certifying Nurse Practioner: To the best of my knowled 29b, Signature and title of certifier	dge, death occurred at the time, date 29c. License number		e cause(s) and manner as 29d. Date signed (Mont			
	Z ≥ Z 2		Anil h Marin IMA	D5068		01/16/	2011		
			30. Name and address of person who completed cause of death (Item 23a) (Ty			mp son	7.4250		
		İ	maryland Hospital 7503 su		9 chint	270	20735		
	Stat	е	31. Date filed (Month, Day, Year) 32. Registrar's Signature	,					
	Registra	ir,	AUL A T CALL TOWNED PO. MANOR						

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician 3 2011 7:30 Atkinson February Harriette Seely /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A Keswick Multi Care Center Baltimore City Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) August 22,1929 If Under 1 Year | If Under 24 Hrs Months Days Hours Min. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Months 1□M 2√F 81 Yrs 242-36-933<u>5</u> Virginia **Director** Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location r 28a-f show notified at 10a. State 10b. County 1 ☐ Yes 2X No Director Maryland 10e. Street and Number Baltimore Towson 10g. Citizen of What Country? 10f, Zip Code r than "natural", or items 23a or 3 the Medical Examiner must be n 21204 **USA** 8101 Bellona Avenue - Arden Courts Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: WHITE þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) nd Mental Hygiene. marked other than College (1-4or 5+) Elementary/Secondary (0-12) Mental Health Psychologist 5+ years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event once, Be Lena Virginia Boyce-Seely Baker Boyce ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1400 Front Avenue, Suite 200 Lutherville Phyllis J. Erlich/Lawyer 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition ☐ Burial 2 Cremation 3 ☐ Removal from State Metro Crematory Inc. Feb 7, 2011 Baltimore, Maryland 5 ☐ Other (Specify) Funeral Service Licensee Patrik Fleming 22. Name and Address of Facility Cremation Society Of Maryland INC 21. Signature of 299 Frederick Road, Baltimore, Maryland Approximate Interval Between Onset and Death Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Immediate Cause (Final herings lear **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any leading to firm evidencesses. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of: Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physician Physician/Medical the attending pl for use as t 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☑ No 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an autopsy 1 Yes 2 No the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☑ No Certification: To 28d. Describe how injury occurred 28b. Time of 28a Date of Injury 27. Manner of Death 28c. Injury at Work? After (Month, Day Year) 1 Matural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No after death. I Director: Ald in by the fu 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To the Funeral Dir completely filled in 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the 29c. License number 29d. Date signed (Month, Day, Year)

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State Registrar FEB 0 8 2011

Server A. Santure

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Charles St. Bolto. Md Zc Zox

in.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Dav Month 2:30 AM **Physician** Margaret Austr
4a. Facility Name (#Hot institution, give street and number) 2011 February \*/Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore City Genesis Caton MANOT If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign County) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number Year **Funeral** 215-22-5667 Hours Min. Days Months 1 □ M 2 P 85 1925 Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10a. State 10b. Count Show r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 Tes 2 No Director More 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number death v Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Austin Black, White, etc. 1 Tes No If Yes, Give Year or Dates: filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 Specify: DITE þ 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) injury or other traumatic event, 17. Father's Name (First, Middle, Last) Be Wilson \_Agnes Vinnie ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Onatory ddress of Favilty 1 ☐ Burial 🛕 Cremation 3 ☐Removal from State 2011 5 Other (Specify) 4 Donation 21223 Jeral Service Licensee 21. Signatut any BUDD Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 45 **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and the burial-transil death certificate be executed Due to (or as a consequence of) Box 68760, Physician/Medical as IF FEMALE: nse 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year for in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.0. the 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed Deen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed' certificate 1□ Yes 2 1/1 No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA P this Manner of Death 28a. Date of Injury (Month, Day Year) 28h Time of 28d. Describe how injury occurred Injury at Work? al or Attending P Certification: Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: completely filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours af To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number HUNYONDA B MUM 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6095 larguita 32. Registrar's Signature 31. Date filed (Month, Day, State FEB 08 2011 Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ FEBRUARY 3, 2011 11:15 PM CARL FREDERIC ACKERMAN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HARFORD UPPER CHESAPEAKE MEDICAL CENTER BEL AIR Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 D F Hours May 18, 1921 Pennsylvania 89 Director 040-18-7451 Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location death with the Maryland Director ems 23a or 28a-f sh r must be notified a 1 🗆 Yes 2 🔀 No Bel Air Maryland Harford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21015 1820 S. Fountain Green Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Completed by 1 Yes 2 No Specify: White 3 ₩idowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) than Elementary/Seconday (0-12) College (1-4 or 5+) Chemical Manufacturer Senior Products Specialist Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental f Mary (nmn) McLain Frederic Jacob Ackerman 19a. Informant's Name/Relationship (Type, Printagaughter . ege 1 and 2 shc Jepartment of Health and Important: If item 27 is many injury or other 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret K. Dallam / In Law 1912 S. Fountain Green Rd, Bel Air, Maryland 21015 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Towson, Maryland Hilltop Service Corp 2-8-11 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatory Fund I Service Mensoe <sup>2</sup>McComas Furferal Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Pnysician/ a UPPER GASTROINTESTINAL disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Due to (or as a consequence of) If any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months? Month Day Year 9 Hinknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by FIBRILLATION 1 Yes 2 No 3 Probably 4 Unknown RENAL INSUFFICIENCY 24b. Were autopsy findings available prior to completion of cause of death? CHRONIC 24a. Was an autopsy 1 Yes 2 No Yes 2 Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 I DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Cartifying Nurse Practioner: To the best of my knowledge Whyanton 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) I NORTH BEL ALR 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 08 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February 2011 1545 McIndoe Arnold Alan Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Montgomery Rockville Shady Grove Adventist Hospital 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number **Funeral** June 20 1**X** M 2 □ F Months Hours Min 216-30-2063 Maryland Director 78 Usual Residence of Decedent or 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Funeral Director traumatic event, the Medical Examiner must be notified 1 Yes 2 No Rockville Maryland Montgomery 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a 20851 United States 1402 Bernerd Place 12. Was Decedent Ever in U.S. Armed Forces?

1★ Yes 2 No
If Yes, Give
Year or Dates. 1950-52 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married should be filed within 72 hours after and Mental Hygiene. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Central Intelligence College (1-4 or 5+) Elementary/Seconday (0-12) Communication Technician Agency Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ James Arnold permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic Margaret Reed 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Lou Arnold/wife 1402 Bernerd Place Rockville, Maryland 20851 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐ Burial 2 【XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2/9/2011 Journey Crematory Woodbine, Maryland 21. Signarire of Funeral Service Ligense 22. Name and Address of Facility Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P. A. Clarksville, MD 21029 M00957 Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Priysician/ disease or condition resulting in death) Pneumon Medical Due to (or as a consequence of) Examiner Tra Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examiner attending physician and for use as the burial-transil Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day 1 Yes 2 9 Unknown ed by the a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 🎾 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Yes 2 No 1 Yes eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? 2 X No Other: 1 Impatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred atural 5 Pending 1 Yes 2 No Accident Investigation Suicide
Homicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the Hosp within 24 hou To the Funer completed fill (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier in. u 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rockeville MD 20850 10110 Molecular MP 31. Date filed (Month, Day, Year) State FEB 0 8 2011 arked Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) February 04, 2011 **Physician** 4:45 P.M Josephine Mary Alfonsi /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore County Manor Care Ruxton Towson 8. Date of Birth (Month, Day, Year) Oct. 19, 1925 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Hours Days 1 ☐ M 2 🕇 F Yrs. Baltimore, MD. 85 214-24-0294 Director Usual Residence of Decedent should be filed within 72 hours after death with the Maryland and Mental Hygiene. s marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 ☐ Yes 2X No Maryland Timonium Director Baltimore County 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number a or United States 505 Limerick Circle 21093-7717 Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married White 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) traumatic event, the Tamburo, Inc. Bookkeeper 12 N/A 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) rith and Mental F. Be Mary Catherine Carnaggio Anthony Joseph Tamburo 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) ( Dauchter) permit. Pages 1 and 2.
Department of Health at Important; If Nem 27 Is any injury or other travonce. Pages 1 and 2 unit 102 Timonium, MD. 21093-6791 Miss Antoinette M. Alfonsi 1 Gandson Court 20b. Place of Disposition (Name of 20c, Location - City or Town, State Date 20a. Method of Disposition Monday (Baltimore County) Dulary Valley Menorial 1 Burial 2 ☐ Cremation 3 ☐Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Reb. 07, 2011 Timonium, Maryland **Gardens** 21. Signature of Funeral Service Licensee Jeffrey L. Gair, Sr. Feareful Alternatives Fureral & Creaming and the death of Peaceful Alternatives Funeral & Cremation Center, P.A. Timonium, Maryland Approximate Interval Between Onset and Death Domenhou Stage mediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Due to (or as a consequence of) Box 68760 requires that the death certificate be Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 4□Pregnant at time of death 5 Other (specify) P.0. signed by the 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by 1 | Yes 2 | No 3 | Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificate has autopsv performe 2☑No or Vital Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 2 ER/Outpatient 3□ DOA 1 ☐ Yes 1 Inpatient Certification: To 27. Mayner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Natural 5 ☐ Pending investigation Division 1 ☐ Yes 2 ☐ No 2 Accident after death 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 0 within 24 hours a

To the Funeral L 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier er: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 2 Medical Exa (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 12-04-11

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State 31. Date filed (Month, Day, Year)
Registrar FEB 0 8 2011

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30. Name and andress of person who completed cause of death (Item 23a) (Type, Print)

M. D.

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	1 - For State Registrar		Cei	tificate of Deal	th	Reg. No	).	3230				
ician dical	1. Decedent's Name (First, Middle, La Edward Alexa					Date of Death Month 4 <sup>Da</sup>	2011	3. Time of Death 7:15 A				
niner	4a. Facility Name (If not institution, gir Future Care Nort)			4b. City, Town, or Location Balt	on of Death	40	4c. County of Death N/A					
al or	213-30-5459		s. last birthday) 79 Yrs.	If Under 1 Year If Und Months Days Hour	der 24 Hrs. 8. [ rs Min. J	Date of Birth Month 1 Day, Year an 1 , 19	9. Birthp	olace (State or Foreigntry Maryland				
ctor	Usual Residence of Decedent  10a. State 10b. County  MD N	10d. Inside City Limit:										
Funeral Director	10e. Street and Number 1024 S. Decker A	venue, Apt. 10	24		ited States							
To Be Completed by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ∰Yes 2 Mo If Aes, Give Year or Dates:		Nas Decedent of Hispanic f Yes, specify Cuban, Mexi I ☐ Yes 2  No Spec		Yes or No- in, etc.)	14. Race - Americ Black, White, Specify:					
Completed by	15. Decedent's E (Specify only highest gr		(Give	lent's Usual Occupation kind of work done during in DO NOT use retired)  US Navy	nost of working	16b. h	(ind of Business/In					
Be Co	17. Father's Name (First, Middle, Las.	Milita n Sumame)	ıry									
To	Columbus E. Beck  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  Mildred Sayago / Nicoo											
	Mildred Savage / Niece  2908 E. Baltimore St., Baltimore, Maryland 21224  20a. Method of Disposition  1  Burial 2 Cremation 3  Removal from State  20b. Place of Disposition (Name of cemetery, crematory or other place)											
	Deliver of Funeral Service Licensee Alyson K Taylor   Signature of Funeral Service Licensee Alyson K Taylor   Signature of Funeral Service Licensee Alyson K Taylor   Property of Oliver places   O2/05/2011   Baltimore, Maryland   Daylor   Signature of Funeral Service Licensee Alyson K Taylor   Signature of Funeral Service Licensee Alyson K Taylor   Signature of Funeral Service Licensee Alyson K Taylor   Signature of Facility Cremation Society of Maryland   Signature of Facil											
	23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition	iplications that caused the de y one cause on each line.		er the mode of dying, such	as cardiac or re	spiratory arrest.	Maryland	Approximate Interval Between Onset and Death				
er	resulting in death)	b. Due to (or as a const		ang	Cara	homa						
edicai Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  C.  Due to (or as a consequence of):											
Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		23d. Date of delivery Month Day Year									
Ď	236. Did tobacco use contribute to the ca											
Completed		24a. Was an autopsy performed?	prior to co death?	psy findings available mpletion of cause of								
o Be	25. Was case referred to medical examiner?  1 Yes 2 1	Hospital: 1 ☐ Inpatient 2	□ ER/Outpatien	Chac	ace of Death (CI		6 □Other (Specif	(v)				
Certification: T	27. Manner of Death  1 Natural 5 Pending 2 Accident investigatic 3 Suicide 6 Could not by	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? M 1 ☐ Yes 2	28d.	Describe how inju		77				
Certifi	4 Homicide determined	building, etc. (Spec	city)			City or Town, Stat						
Medicai	one)	hysician: To the best of my k miner: On the basis of exami and manner stated.	nowledge, death nation and/or inv	estigation, in my opinion,	death occurred a	due to the cause(s t the time, date an	s) and manner as s d place, and due to	tated. the cause(s)				
2	29b. Signature and title of certifier	M.D		29c. License numb	9540	29d. Da	ate signed (Month,	2011.				
	30. Name and address of person who	completed cause of death (It	em 23a) (Type,	evels Pd	515	204 5	۰ ام . ۱۱	MD				

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2 Date of Death 3. Time of Death 4:08 1 Day 6 Physician/ Februar a 2011 Medical 4a. Facility Name (if not institution, give stre 4b. City, Town, or Location of Death Examiner County of Death Burnie ANNE Medical Center Washington Glen 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Age (In yrs. last birthday) 9. Birthplace (State or Foreign 6. Sex **Funeral** 1 🛣 M 2 🗆 F Months Days Min 152-26-6419 Yrs. **Director** Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1 Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? SA 12. Was Decedent Ever in U.S. Armed Forces?

1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 9 Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. 3 Widowed 4 Divorced HMERICAN or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I and 2 should be filed within 72 f Health and Mental Hygiene. Item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) TRUCK DrivER ARmo C Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည LIKE 19a. Informant's Name/Relat in (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Odenton Jacqueline 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Burial 2 Cremation 3 Removal from State Important: If any injury or once, Crownsuite MARYAND Ransville V.A CEM. 4 ☐ Dopation 5 ☐ Other (Specify) 14.2011 e of Funeral Service Licensee 22. Name and Address of Facility Wancy M. Walke Funeral Service 3405 W. Street 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death Ph sician/ disease or condition resulting in death) Medical t (or as a consequence of): Examiner Requireficity liet expeditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No Yes 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) þ Hospital 2 No Other: 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Deat 1 Natural 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 5 Pending Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 1 Dertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signatu 29c. License number 2011 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CANTRIA 30 32. Registrar's Signature 31. Date filed (Month, Day, Year) State FEB 08 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ HEINO BORN 201 heb Medical 4a. Facility Name (if not institution, give street and number) County of Death 4b. City, Town, or Location of Death Examiner Medical Cont Glen 7mort 8. Date of Birth
(Month, Day, Year
Feb. 24, Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** <sup>year)</sup>1930 Days Country) 1 🗷 M 2 🗆 F Hours 80 245-44-6445 Director onia Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f shoury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🗷 No Pasadena <u>Maryland Anne Arundel</u> 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21122 624 Sutton Drive 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 1 Tes 2 No Specify Specify: White 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Johns Hopkins Electromechanical Eng. Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Kalm Erika Herbert L.Born 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Md3420 Kirby Kountry Dr. Tanevtown, Ladon (Godson) Pau1 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any injury or ot 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 02-07-11 Glen Burnie, Md. Atlantic Crem. 22. Name and Address of Facility McCully-Polyniak FH P.A. Signature of Functal Service Licenses Mountain Rd. Pasadena. Md 23a. Pur 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. nprediate Cause (Final Onset and Death Physician sease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** nem U Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events attending physician and for use as the burial-transit 0 Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence) of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 9 Unknown Division of Vital Records, P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 1 Tes page 2 should has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completed filled in by the funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🕱 No မ Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) 1 🔀 Natural 5 Pending work? 1 Yes 2 No Investigation 2 Accident 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 041 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Medical Center Glen Bung. Many brid

State Registrar

arke

32. Registrar's Signature

Cho

31. Date filed (Month, Day, Year) FEB 0 8 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day EVELUNEBUSTON 12:36 p M Ennian Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death PRENTISS ALTIMORE 5. Social Security Number 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 09-16-7. Age (In vrs. last birthday 9. Birthplace (State or Foreign Funeral 1 🗆 M 2 🗶 F 217-32-9093 75 Director MARYLAND "natural", or items 23a or 28a-f show edical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director BALTIMORE 1X Yes 2 ☐ No MD 10e. Street and Number 10g. Citizen of What Country? Funeral PLACE USA PRENTISS 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian. þ 1 Never Married 2 Married 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 KNo Specify. Specify: BIACK Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) MD STATE OF DIVISION OF PAROLE & Probation Elementary/Seconday (0-12) College (1-4 or 5+) ECRETARY Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BALTO Daughter MΩ 20a. Method of Disposition

1 ■ Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Baltimore, MD 4 Donation 5 Other (Specify) KING 21. Signatur of Funeral Ser GREENE PUNERALSON 22. Name and Address of Facility VAUGHN 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Atheroselerotic ardiovascular Disease Onset and Death Physician disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Securitielly intronditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery st 12 months? 2 No in the past 12 Dav Year Pregnant at time of death sate has been signed by the page 2 should be detached Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 □ No B B 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 □No Other: မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA After this 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide determined Medical 🕪 ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Decrimed at the time. Safe and plans, and due to the equee(e) and manner as state 29c. License number 29d. Date signed (Month, Day, Year) nstlyapatrem.D D0057465 214/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, MD . 21209 ROYAPAKHMD 2835 Smith Av-5-203.

DHMH 17 Rev 7/2009

Registrar

31. Date filed (Month, Day, Year)

FEB

08 2011

32. Registrar's Signature

		For State	Plea	ase Type or I State of		nd / Depa		nt of H	lealth and	Mental H	ygiene	201	oie.	03260
Physicia		Registrar  1. Decedent's Name  Mahmood	e (First, Middle		med	<u>Oei</u>		abaq:		2. Date of D Month	Reg. No leath Da		ear	3. Time of Death
Medic Examin	er			, give street and numb			T	, Town, or	Location of Dea	th	4c. County of Dea			
Funeral Director		5. Social Security Nu		. Age (In yrs.	Age (In yrs. last birthday) Yrs.  If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 60				s. 8. Date of B	irth Day, Year) 2			lace (State or Foreign	
a-f show fied at	ctor	Usual Residence of 10a. State MD	10b. County	gomery	10c. City, Town or Location Silver Spring									0d. Inside City Limits
23a or 28 ist be noti	Funeral Director	10e. Street and Num	nber	Circle	10f. Zip Code						10g. C	itizen of Wha		
Department of the subject of the sub	by	11. Marital Status  1 Never Marri 3 Widowed	ied 2 🗆 Mari	12. Was Deced Armed Force ried 1 Yes	ent Ever in U es? No	Ever in U.S. 13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl					)-			
ene. than "natur he Medical	Completed	Elementary/Seco	cify only highe	college (1-4		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  N/A						Kind of Busin	ness Ind	ustry
nental Hygie rked other tic event, t	ro Be	N/A  17. Father's Name (F  Ahmed Ba		<del></del>	] [N	/ A _			ame (First, Middle	e, Maiden				
Health and M tem 27 is ma other trauma		20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - Ci											MD1	ver Sprin
Department of Important: If it any injury or conce.		1X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) King Memorial Park 2/3/2011 Woodlawn, Md  27. Signature of Funeral Service Licensee    22. Name and Address of Facility Warch F/H West												
nysician/ Medical xaminer		shock, or hear Immediate Cause (F	Approximate Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between Conset and Death disease or condition resulting in death)  a.   Extreme Prematurity  Due to (or as a consequence of):  Preterm Rupture Of Membranes											
an and rial-transit	lical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Preterm Rupture Of Membranes  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):												
within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the but the but the funeral director.	Physician/Medical	1 Live Birth 2 Fetal death 3 Ectopic pregnancy										23d. Date of Month	e of delivery hth Day Year	
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cate has be page 2 shc	Completed									per	s an opsy formed? 2 1 N	prio dea	r to con th?	sy findings available npletion of cause of 2  No
his certifi	To Be	25. Was case referre examiner?  1  Yes 2	No			] ER/Outpatier		Othe	r: 4  Nursing	eck only one)  Home 5 $\square$ Res	idence (	6 Other (	Specify)	
fter death. irector: After t n by the funera	Certificate:	27. Manner of Death  1 Natural 5 Pending Investigation 3 Suicide 4 Homicide determined  28a. Date of injury 28b. Time (Month, Day, Year)  28b. Place of Injury - At home, farm, similarity 2 building, etc. (Specify)						28c. Injury at work?  M 1  Yes 2  No				how injury occurred  (Street and Number or Rural Route Number,		
n 24 hours a e Funeral D	Medical (	(Check 2	Medical E	Physician: To the best xaminer: On the basis Nurse Practioner: To	of examination	on and/or invest	tigation, in	my opinio	n, death occurred	d at the time, date	and place	e, and due to	the cau	se(s) and manner stated
To the comp		29b. Signature and t		Douath	, MC	)	29	c. License			29d. Da	ate signed (A	Aonth, E	ay, Year)
State Registra	е	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Dr. Nicola Dequattro MD.1400 Forest Glen Road, Silver Spring, M. 31. Date filed (Month, Day, Year)  32. Registrar's Signature  FEB 0 8 2011										Md 20910		

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ URREL Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death N/A 816 Herndon Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 □**X** Months Maryland 087027 7964 Director 46 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location **Funeral Director** 10d. Inside City Limits 1 X Yes 2 □ No Baltimore N/A MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21239 1907 Swansea Rd. 12 Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 S No
If Yes, Give
Year or Dates. Black, White, etc. 2 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 Divorced 4 Divorced Completed Black 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Addiction Counselor Self Employed years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Barbara Ann Keys Thomas Edward Burrell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2607 Welsh Rd., Apt E206, Philadelphia, PA Anthony Marshall (husband) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 02/01/11 Baltimore, MD 4 Donation 5 Other (Specify) King Mem. PArk 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 2140 N. Fulton Ave., Euneral Home PA217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year 1 Yes 2 9 Unknown the 9 Unknown been signed by should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 Yes 2 No 3 Probably 4 Unknown this certificate has been ral director, page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed Yes 2 death? 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? sister's 2 No မ 1 🗌 Yes Other: 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home Residence 6 Nother (Sp funeral Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at eral Director: After filled in by the funer 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending work 1 ☐ Yes 2 ☐ No Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4  $\square$  Homicide determined City or Town, State) 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number lov 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ano B mo 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ARTHUR H. BROWN FEBRUARY 3.12 amm 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death WASHINGTON MEDICAL CENTER BURNIE ARUNDEL ANNE BALTIMORE GLEN Social Security Number 8. Date of Birth (Month, Day, Year) rebruary 28,1926 Funeral 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 1**X** M 2 □ F Hou*r*s 217-22-5016 **Director** 84 Tennéssee permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at one. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland N/A Brooklyn 1 ¥ Yes 2 ☐ No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 602 Arsan Avenue 21225 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ★ Yes 2 □ No
If Yes, Give Black, White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify: White 3 X Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) General Motors Corp. Assemblyman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Marshall Brown Georganna Hicks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catherine Copeland (Daughter) 705 Hamlen Road, Glen Burnie, Maryland 21061 Baltimore, BROWN, A 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Glen Haven Mem. Park 4 Donation 5 Other (Specify) Feb. 09,2011 Glen Burnie, Maryland 22. Name and Address of Facility McCully-Polyniak Funeral Home P.A. 21. Signature of Funeral Service License 237 East Patapsco Avenue, Baltimore, Maryland 21225 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph\_sician/ infarction "yocardia) disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any leading to immediate ue to for as a consuluence of cause. Enter Underlying Cause (Disease or iinjury Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending properties for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No 4 Pregnant at time of death
9 Unknown Month Day Year signed by the a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ancer 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of After this certificate has funeral director, page 2 autopsy death? 1 ☐ Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No 1 🗌 Yes Certificate: To 1 Suppatient 2 ER/Outpatient 3 DOA

28a. Date of injury
(Month, Day, Year)

28b. Time of injury
injury 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Deat 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accider 5 Pending ours after death. leral Director: Aft filled in by the fur 1 ☐ Yes 2 ☐ No Accident Investigation Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only on nd title of certifier 29b. Signa 29c. License number 29d. Date signed (Month, Day, Year) 07126 person who completed cause of death (Item 23a) (Type, Print)

award

31. Date filed (Month, Day, Year FEB 0 8 2011

ARTHUR

DHMH 17 Rev 7/2009

Registrar

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Yeer Month 4-000 -14-197 oz 03 2011 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Roland anle 13014 Maror coe Baltimur (nu-If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth Days Hours Min. Months 02/09/1928 1 M 2 KF 212-22-4140 82 Virginia Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County 1 SYes 2 □ No MD N/A Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4669 Falls Rd. 21209 U.S.A.

14. Race - American Indian,
Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 11. Marital Status 1 Never Married 2 Married Specify: Black 1 Yes 2 XNo Specify: 3 ☑ Widowed 4 ☐ Divorced Year or Dates: 16b. Kind of Business/Industry Baltimore City 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Schools Teacher years 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Mary Lampkin Nash Bush 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1202 Wildwood PKWY, Baltimore, MD 21229 John R. Brown(son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition M□ Burial 2 □ Cremation 3 □ Removal from State King Park Mem. 02/08/11 Baltimore, MD \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 2 Name and Address of Facility 2140 N. Fulton Ave., Funeral Home repuch NIU 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as-a Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a c resulting in death) Last Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 2 000 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 2 1 No 1 Yes 2 No 1 Yes 25. Was case referred to medical examiner?
1 Yes 2 Yes 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27 Manger of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work?

1 Yes 2 No

K126363

8813 walthan woods

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

/Medical Examiner the attending physician and the dor use as the burial-transit The law requires that the death certificate be exec Division of Vital Records, P.O. Box 68760 signed by the a peen has page 2

this certificate funeral After

**Physician** 

/Medical

Examiner

Director

by Funeral

Completed

Be

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**Funeral** 

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or itema 23s or 28a-f show

permit. Page Department of Important: If

**Physician** 

any injury

Baltimore, Maryland 21215-0036

other traumatic event, the Medical Examiner must be notified at

or Attending Physician: in by the To the Funaral Director: To the Hospital

Physician/Medical Completed by Be 2 Certification:

Netural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

Examiner

within 24 State Registrar

Medical 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (

5 Pending investigation

6 Could not be determined

FEB 0 8 2011 32. Registrar's Signature

DHMH 17 Rev 1/2001

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 4a. Facility Name If not institution, give street and number) **Physician** /Medical 4c. County of Death 4b. City, Town, or Location of Death **Examiner** NIA **Baltimore City** The Johns Hopkins Hospital Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number Min. **Funeral** Months Hours 1 M 2 - F Days 224-14-613 une Director Usual Residence of Decedent 3a or 28a-f show t be notified at 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 1 Ves 2 □ No Director NIA 10g, Citizen of What Country? 10f. Zip-Code 10e. Street and Number 2120 23a ( alle Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 "natural", or 1 🗌 Yes 2 No Specify If Yes, Give Year or Dates: Specify: 9 3 Widowed 4 Divorced 16b. Kind of Business/Industry Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education the Medical (Specify only highest grade completed) College (1-4 or 5+) than Elementary/Secondary (0-12) is marked other 18. Mother's Name (First, Middle, Maiden or other traumatic event, 17. Father's Name (First, Middle, Last Be ည 19b. Mailing Address (Street and Number or Rural Route Number City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) MD 21202 permit. Pages 1 and 2 Department of Health a Important: If item 27 Is 20c. Location - City or Town, 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee any Balto. Approximate Interval Between 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such a cardiac espiratory arrest, shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final disease or condition resulting in death) ardiapulmonar **Physician** /Medical Due to (or as a con equence of): Examiner myocardial Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner a conse vience of Distance for the The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) attending physician Box 68760 Physician/Medical IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy Year in the past 12 months? Pregnant at time of death 5 Other (specify) 1 Yes 2 9 Unknown 2 No Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has 2 No 1 Tyes 2 No To the Hospital or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: 1 Inpatient Other: 4 \sum Nursing Home 3 🗌 DOA 5 Residence 6 Other (Specify) 2 🗌 No 2 ER/Outpatient ည 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: within 24 hours after death. To the Funeral Director: After Injury 1 Natural 5 Pending investigation 1 🗌 Yes 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (check only within 2 29c. License number 29b. Signature and title of certifier RES-000 7.7 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe St, Baltimore, MD, 21287 Khandker

State Registrar 31. Date filed (Month, Day, Year)

FEB 08

32. Registrar's Signature

Division or Vital Records, P.O. Box 68760.

I or Attending Physician: after death. Director: After this certific Certification: Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours aft To the Funeral D 29a. Certifier Mcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and Little of certifier 29c. License number 29d. Date signed (Month, Day, Year) KES - 000 101 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PORTO 4940 EASTERN AVENUE BALTIMORE, MD 4MD FERNANDA 31. Date filed (Month, State 8 Registrar DHMH 17 Rev 1/2001 **ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Theodore Thompson Brundage Medical February 2011 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Raltimore
If Under 1 Year Tif Under 24 Hrs. Emeritus of Towson 9. Birthplace (State or Foreign **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth Min. Days Country) EW York 1 X M 2 - F Months 01/10/1920 91 Hours Director 071-16-0409 New Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location Director Maryland Baltimore City Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 6451 Charles Street #222 21212 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 Married 1 ¥ Yes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White and Mental Hygiene. 3 Divorced Year or Dates. WWII permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygene. Important: If item 27 is marked other than "naturaly injury or other traumatic event, the Medical. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Aeronautical Engineer Engineering Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Herbert J. Brundage Helen Thompson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Laura Manuel/ Daughter 619 Turnberry Drive, Charles Town, WV 25414 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place, 04/21/2011 Woodlawn Newburgh, NY 21. Signature of Funeral Service License 22. Name and Address of Facility Towson, MD 21204 Ruck Towson Fu<u>neral Homé</u>, 1050 York Rd 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ mant disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examin Cause (Disease or linjury that initiated events the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last anding physician use as the buria Physician/Medical Box 68760 IF FEMALE. 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No ate has been signed by the atte page 2 should be detached for Month Pregnant at time of death g Unknown 9 Unknown P.O. Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 ☐ Yes 2 ☐ No ☐ Yes 25. Was case referred to medical of Vital completed filled in by the funeral director, Be 26. Place of Death (Check only one) Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at After 1 Certificate: 28d. Describe how injury occurred Natural 5  $\square$  Pending injury Division after death. 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one no title of certifier 29d. Date signed (Month, Day, Year) 2 20 M lex! 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701N Charles NORMA HUMBURS 32. Registraris Signature Bark

3. Time of Death

10d. Inside City Limits

Interval Between

Onset and Death

Year

Assired Win

Facilis

ens

1 X Yes 2 No

8:30

Registrar

11-00987 Brian Brockmeyer

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible,

Brian Brockmeye		State of Maryland / Department of Health and Mental Hygiene 1-For State Registrar  Certificate of Death Reg. No.											
Physicia Medical Exami	ın/	Decedent's Name (First, Midd	e,Last) Brian	0	Brockm	eyer		2. Date of Deat Month February 4	th	3. Time of Death 1940 hrs			
		4a. Facility Name (if not institution Hopkins Bayview Med	. •	nber)		b. City, Town, or L Baltimore	ocation of De		4c. County of De				
Funeral Director		5. Social Security Number 218-80-0255	6. Sex 1 X M 2 F	7. Age (In yrs.	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24	/lin.	1=				
any		Usual Residence of Decedent  10a. State 10b. County			, Town or Location	n l		Aug. 2	23,1937	10d. Inside City Limits			
	Director	MD 10e. Street and Number	Balt <u>imore</u>			10f. Zip Code	Dunda		1 Yes 2 X No				
nith the Maryland 123a or 28a-f sho 1 notified at once		2968 Sol1	ers Point		13 Was	21222	anic Origin? /	Specify Ves or No.	United S				
hours after death with the Maryland natural", or items 23a or 28a-f she Examiner must be notified at once	by Funeral	1	Armed For 1 Yes Orced If Yes, Give Year	ces? 2 <sub>X</sub> No	If Ye	s, specify Cuban, I Yes 2🗶 No	Mexican, Pue	rto Rican, etc.)	Specify Yes or No- to Rican, etc.)  14. Race - America White, etc.  Specify:  White				
2 3	Completed	15. Decedent's Education (Spe Elementary/Secondary (0-12) 12 Years	cify only highest grade College (1- 1 Year		during mo	s Usual Occupatio st of working life. I ory Mech	OO NOT use i		Plastic	e Products			
MD 21215-0036 12 should be filed within 7 th and Mental Hygiene. 127 is marked other than umatic event, the Medica	Be	Michael J. Brockmeyer, Sr. Mar							me (First, Middle, Maiden Surname) ry C. Ayd				
MD 2 nd 2 shoul slth and N m 27 is m numatic	۱٩								or Rural Route Number, City or Town, State, Zip Code) Road Dundalk, Maryland 212				
Baltimore, MD 2121 bermit. Pages I and 2 should be fil Department of Health and Mental I Important: If item 27 is marked nijury or other traumatic event,		1 Burial 2 Cremation  4 Danation 5 Other St	_	n State	crematory or other		· 1	Date /9/2011	Towson,				
Baltimo permit. Pages Department o Important: 1 injury or oth		2). Signature of Funeral Service	Licensee	W//	79	22 Wise	Ave. D	undalk. M	Dundalk, Maryland 21				
Physician Wedical Examiner		23a. Part I. Enter the disease, or failure. List only one cause Immediate Cause (Final disease	complications that cau on each line. a. Bleeding du	/		mode of dying, su	uch as cardia	c or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and Death			
	_	or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):											
ıted d ansit	Examiner	cause. Enter Underlying Cause (Disease or mjury that initiated events resulting in death) Last	Due to (or as a c				_						
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Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate b within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the bu		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unk	e 1 Live bir	nt at time of de	2 Feta	death 3	Ectopic preg	nancy	23d. Date of delive Month	ery Day Year			
ords, P.O. B. requires that the de .been signed by the should be detached f	≦	Part II. Other significant conditi	ons contributing to c	leath but not re	esulting in the un	derlying cause give	en in Part I.		bacco use contribute t	o the cause of death?			
Division of Vital Records, P.O. rat or Attending Physician: The law requires that it is after death.  at Director: After this certificate has been signed by led in by the funeral director, page 2 should be detacted.	Completed							24a. Was a autops perform	sy prior to med? death?				
Vital Rec	To Be	25. Was case referred to medical examiner?  1 ✓ Yes 2 No	Hospital: 1 Inc	patient 2	ER/Outpatient		Death (Chec		Residence 6 Oth	er:			
ion of V tending Phy leath. tor: After tl		27. Manner of Death  1  Natural 5 Pend	28a. Date of (Month, D tigation	Injury Day,Year)	28b. Time of Inju		at Work?	28d. Describe he	ow injury occurred				
Division  To the Hospital or Attentwithin 24 hours after death To the Runeral Director:	Certification:	3 Suicide 6 Could 4 Homicide deter		of Injury - At ho	ome, farm, street,	factory, office buil	ding, etc.	28f, Location (St or Town, Sta		Rural Route Number, City			
To the Hospital within 24 hours 4 To the Runeral completely filled	ल			examination a					e(s) and manner as sta and place, and due to t				
	Ž	29b. Signature and title of certifier	elffull			29c. License n			29d. Date signed (Miles February 5, 201				
AV.		30. Name and address of person Margarita Korell MD.	Assistant Medic	cal Examin	er 900 W. I	Baltimore Stre	et, Baltim	ore, MD 21223	3				
Sta Registr		FEB (8 2017 Year)	Jenera 32. Red	strar's 80000	Kal		-						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death February I, 2011 Physician/ Brashewitz 1:45 Рм Frank W. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Catonsville Frederick Villa Nursing Home Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 1 X M 2 □ F Months Days Hours Nownth, 8ay, 1935 75 Yrs **Director** Maryland 213-32-7603 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location iral", or items 23a or 28a-f sho Examiner must be notified at Director 1 Yes 2 X No Glen Burnie Anne Arundle Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 304 Ferndale Ave. United States 21061 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Ongin? (Specify Yes or No-14. Race - American Indian, 11. Marital Status Black, White, etc. White rmed Forces? XYes 2 □ No 1961 If Yes, specify Cuban, Mexican, Puerto Rican, etc.) þ 1X Never Married 2 ☐ Married filed within 72 hours after Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates 1965 "natural" Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Construction Brick Layer 10th N/A Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Mental. Important: If item 27 is marked cany injury or other traumatic eve ပ Wendling Elizabeth Frank Brashewitz 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1919 Oak Hills Drive, Hanover, Pennsylvania 17331 19a. Informant's Name/Relationship (Type, Print) Charles D. Lowman/ Brother Baltimore, 20b. Pice of Disposition (Name of Mary Pander (Name cremesce) Cenetery (Crownsville 20a. Method of Disposition 20c. Location - City or Town, State Removal from State 4 Donation 5 Other (Specify) Crownsville, Maryland 7,2011 Signature of Funeral Service Dicense 22. Name and Address of Facility Ambrose Funeral Home, 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Chroni Physician/ Pulmonary Obsmulive disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): attending physician and for use as the burial-transil Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 2 No certificate has been signed by the rector, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? 1 Yes 2 No Yes 25. Was case referred to medical the funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work?
1 Yes 2 No 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical 29a. Certifier Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 29d. Date signed (Month, Day, Year) 2/2/11 047683 Taymond Millis-

DHMH 17 Rev 7/2009

State

Registrar

Junte 203

Avenue

racks

Baltimore

21209

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Smith

32. Registrar's Signature

2835

Raymond Miller

31. Date filed (Month, Day, Year)

FEB 0 8 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ John Boback February 04,2011 1:54 P.M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Care Baltimore County Towson 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 X M 2 D F Months Days Hours Director 178-05-5370 91 Feb. 02, 1920 Shamokin, PA. Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City. Town or Location 10d. Inside City Limits Director Maryland Baltimore County 1 Yes 2 No Timonium 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 100 Longdale Road 21093-3439 United States within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 X Yes 2 No Black, White, etc 1 Never Married 2 Married ò Maryland 21215-0036 1 ☐ Yes 2 No Specify. If Yes, Give W.W.II White 3 Divorced Specify: Completed 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 and Mental Hygien is marked other th 04 Manager Bendix Corp. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be fill f Health and Mental item 27 is marked Peter Boback Mary Kotanchick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Brenda B. Tenberg(Daughter) 20019 Bollinger Road Manchester, MD. 21102-2723 Important: If item 2 any injury or other tonce. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)

Dularrey Valley Men. Gardens . Location - City or Town, State (Baltimore County) Page 1 a Wed. o 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Reb. 09, 2011 Timonium, Maryland Signature of Funeral Service Licensee Jeffrey L. Gair, Sr. 22. Name and Address of Facility
Pencerul Alternatives Fureral & Cremation Center, P.A. Lic.#M00677 2325 York Road Timonium, Maryland 21093-2215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ PULMONARY disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner If any leading to immediate cause, Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): To the Hospital or A encing Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No Pregnant at time of death Month 9 Unknown been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ADVANCED DEMENTIA 1 Yes 2 No 3 Probably 4 Unknown Completed After this certificate has been ACUTE RENAL FAILURE 24a. Was an Were autopsy findings available prior to completion of cause of autopsy death? 2 No 1 Yes 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Certificate: To 1 Tes 2 L No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Spe 27. Manne of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural work?
1 \( \sum \) Yes 2 \( \sum \) No 5 Pending 2 Accident
3 Suicide
4 Homicide eath Investigation 6 Could not be Director: 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined within 24 hours a To the Funeral D Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

10+1

State Registrar 31. Date filed (Month, Day, Year) 32. Registrar's Signature
FEB 0 8 2011

ne and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ever Nemitas Ca		1- For State Registrar	ate of Maryla	Certi	ificate of	Death	Mental H	R	20 II i	00250
Physicia Medical Examir	ın/	Decedent's Name (First, Midd	e,Last) Ever N	2 : //	10 100	on-Brito	alderna	Date of Dea     Month     January 2	Day Year	3. Time of Death 0958 hrs
		4a. Facility Name (if not institution 4218 Oglethorpe Stre			e ne	4b. City, Town, or Lo	ocation of Death		4c. County of Dear	
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. las	t birthday)	If Under 1 Year	If Under 24Hrs		rth (MM/DD/YYYY) 9. Bi	irthplace (State or
Director		None	1 M 2 F	La	10 Yrs	Months Days	Hours Min	JULY 3	29,1970 c	ountry) Salvador
uy	F	Usual Residence of Decedent  10a. State 10b. County		10c, City, T	own or Locati	on ,				10d. Inside City Limits
id how as			e George's	1/	yattes					1 X Yes 2 No
Aaryland 28a-f show	Director	10a Street and Number				10f. Zip Code	727	m. 1	0g. Citizen of What Co	
h the N		4218 Ogle	thorpe	5t			2078		EL Salv	
hours after death with the Maryland "natural", or items 23a or 28a-f sho Examiner must be notified at once.	Funeral	11. Marital Status  1 Never Married 2 M	arried Armed Fo			s Decedent of Hispa es, specify Cuban, I			)- 14. Race - Ame White, etc.	rican Indian, Black,
fter des			orced If Yes, Give Yea	2 No	1 🔀	Yes 2 No	specify: 50	lugdor	ian Specify: #13	panic
ours a	ğ þ	15. Decedent's Education (Spe	cify only highest grad	de completed) 1	6a. Deceden	t's Usual Occupatio ost of working life. D	n (Give kind of v	vork done	16b. Kind of Business	/Industry
.7	plet	Elementary/Secondary (0-12)	College (1	-4 or 5+)		Labor			Constru	ction
5-003( ed within Tygiene. other tha	Completed	17. Father's Name (First, Middle,	Last)				3.Mother's Name		Maiden Surname)	
21215-0036 uld be filed within 7 Mental Hygiene. marked other thau	Be	Eugenio	Calder	017			Jose F		Brito	7: 0-1)
and and	۵[	19a. Informant's Name/Relations ELMEN	hip (Type, Print) Ama Va	( Paster)	19b. Mailing	Address (Street a	or be 51	Rural Route Nur	nber, City or Town, State	20 781
_ = = = = =		20a. Method of Disposition		20b. Pla	ace of Dispos	ition (Name of ceme	etery,	Date	20c. Location - City of Santa And El Salv	r Town, State
F E E E		1 Burial 2 Cremation 4 Donation 5 Other S		om State	nente	110: Meta	pan Feb	16/2011	El Salv	aclor
Baltimore, permit. Pages 1 a Department of He Important; If its injury or other to	ı	21. Signature of Funeral Service		T. 1	22. N	lame and Address o	of Facility Sa	macri	UI VIETA	1 Services.
	-1	23a. Part I. Enter the disease, or	complications that co	aused the death. [	o not enter th	00 Kell ne	100 51 uch as -rdiac o	r respiratory arr	Washingfar rest, shock, or heart	Approximate Interval
Physician // // // // // // // // // // // // //		failure. List only one cause	on each line.						,	Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)		cystic Ki consequence of):						1
	<u>_</u>	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	consequence of):						_
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ecuted and and transit	Exa	events resulting in death) Last	Due to (or as a	consequence of):						
0, be executed sician and ourial - trans	dical	X UNPENDED	X AMENDED	1,23a,2	27 per	me g913	3-25-11	vt		
760 icate b g physi	- 00 ⊢	IF FEMALE: 23b, Was decedent pregnant in the		outcome of pregna		tal death 3	Ectopic pregna		23d. Date of delive	ry Day Year
Box 68760 death certificate the attending physical of the attending physical of the attending physical for use as the busing the second of the	iciar	past 12 months?	4 Pregn	ant at time of deat		tal death 3 her (Specify)	_Ectobic blegite	ii icy	World	Day Tour
BO) he deatl	Physician/M	1 Yes 2 No 9 Uni	known g Unkno		ulting in the u	inderlying cause giv	en in Part I	23e Did to	obacco use contribute t	o the cause of death?
that that detz	2	rait ii. Other significant condit	ions continuating to	death but not res	uiting in the c	indertying cadse gre	CITITITI GIVE.		s 2 No 3 Pro	_
ords, w require us been si should b	Completed					·	_	24a. Was		autopsy findings available completion of cause of
ecol he law tte has	틹				·				ormed? death?	
Vital Rec ysician: The his certificate director, page	Bec	25. Was case referred to medica examiner?					f Death (Check			
F Vit	의	1 ✓ Yes 2 No  27. Manner of Death			R/Outpatient			-	Residence 6 Oth	er: Scene
on of anding Ph.	Ë	1 X Natural 5 Pend		, Day,Year)	OD, THIRE OF I		s 2 No	Zod. Describe	now injury occurred	
Division pital or Attend ours after death teral Director: filled in by the	ficat	2 Accident Inve	stigation	e of Injury - At hon	ne, farm, stree	et, factory, office bui	ilding, etc.			Rural Route Number, City
Divinital of ours af	Certification:	4 Homicide dete	rmined (Specify)					or Town, S	State)	
Division To the Hospital or Attend within 24 hours after death To the Funeral Director:		29a. Certifier (Check only one) 2 Medical Exa	<b>hysician:</b> To the bes <b>miner:</b> On the basis	st of my knowledge of examination and	, death occur I/or investigat	red at the time, date tion, in my opinion, c	e and place, and death occurred a	I due to the cause at the time, date	se(s) and manner as sta and place, and due to	ated. the cause(s)
To t with To t	Medical	29b. Signature and title of certific	and manner s			29c. License			29d. Date signed (M	
		Mayeria 1	me Und	le		O.C.M	.E.		January 29, 20	11
11/	1	30. Name and address of persor	•			D-10 5:		- MD 0405	2	
1 /	ل	Margarita Korell MD.		ajetrade Signatilis		. Baltimore Stre	eet, Baltimo	re, MD 2122	<u> </u>	
Sta Regist	-	31. Date filed (Month, Day, Year)	32. Re	egistra/s Signature	Me					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ February Year JOKIN 05 REOCIORE ZMar 201 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Bel Air Brooks Har forcel. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) an. 1, 1926 1 M 2 - F Months Days Hours Min Director 85 Yrs. Pennsylvania 210-16-9883 Jan. Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 ੌ No Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 25 Brooks Road 21014 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. Ś 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify Specify. Completed 3 Widowed 4 Divorced White other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 721 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ne any injury or other traumatic event than "ne once. (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) School Teacher Public Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John (unk) Chizmar Julia (unk) Palai 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia E. Chizmar / Wife 25 Brooks Road, Bel Air, MD 21014 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Air Memorial Gdn 2-8-11 Bel Air, Maryland 21. Signature of Funeral Service License McComas Funeral Home, P.A. Mark 50 West Broadway, Bel Air, Maryland 21014 23a. Part 1. Enter the disease, or complication at the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each the. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Vasular years Medical Due to (or as a consequence of) Examiner accecton t Uasa 400xs Sequentially list conditions, cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of). and -transit The law requires that the death certificate be executed Hypertension 040653 that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the buna Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Dav Pregnant at time of death Month Year signed by the a 1 Yes 2 L 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by MINKOWA Records, 1 ☐ Yes 2 📉 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy page performe death? Yes 2 XNo 2 🗆 No or Attending Physician: 25. Was case referred to medical **Division of Vital** funeral director, Be 26. Place of Death (Check only one) examiner? Hospital: 2 **N**o 1 Tes Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending work? 2 Accident
3 Suicide
4 Homicide 2 🗌 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 🗷 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) felore014 2011

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31. Date filed (Month, Day, Year)

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32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2:30 PM 2011 SYLVESTER FEBRUARY Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner RANDALL STOWN BALTIMORE NORTHWEST HOSPITAL If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth Social Security Numbe **Funeral** 1 M 2 D F Days AUGUST 49-40-544 Months Hours Min. Director Usual Residence of Decedent 28a-f show 10b. Count 10a. State 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 1 Tes 2 No 10e. Street and Number ò 10g, Citizen of What Country? items 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Examiner Black, White, etc. , or \$ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 🗆 Yes 2 🗖 No Specify: "natural" Completed 3 Widowed 4 □ Divorced other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (4-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Page 1 and 2 sl ment of Health a tant: If item 27 is 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite ò Surial 2 Cremation 3 Removal from State injury o 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ba Ho 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ PHEUMONIA disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) and transit Exam death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): -burialanding physician use as the burial Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 ATHEROSCIEROTIC HEART 1 Yes 2 No 3 Probably 4 Unknown DISEASE Records, Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an ATRIAL FIBRILLATION autopsy performed? Yes 2 No Division of Vital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes ပ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending F within 24 hours after death.

To the Funeral Director: After 1 Natural 5 Pending work? 2 🗌 No Accident Investigation completed filled in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: The basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner:
3 Certifying Harse P (Check dtioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and 29d. Date signed (Month, Day, Year)

Registrar

State

31. Date filed (Month, Day, Year)

FEB 0 8 2011

on who completed cause of death (Item 23a) (Type, Print)

AHMED, M.D. 5401 OLD

32. Registrar's Signa

D0060293

COURT RD

RANDAUSTOWN MD 21133

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

11-00954	
Warfield Curry	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Warfield Curry	1- For State Registrar	tate of Marylar		nt of Health a e of Death	nd Mental I		20 i eg. No.	0325
Physician/ Medical Examiner	Decedent's Name (First, Mide		G	_		2. Date of Dea Month February	- Day Year	3. Time of Death 0808 hrs
	4a. Facility Name (if not instituti Union Memorial Hos		Curry ber)		or Location of Dea		4c. County of Dea	th N/A
Funeral Director	5. Social Security Number 219-70-0929		. Age (In yrs. last birthd		ear If Under 24F ays Hours M		th(MM/DD/YYYY) 9. B Fore	
d how any Es.	Usual Residence of Decedent  10a. State 10b. County  MD Ba.	Ltimore	10c. City, Town or	Location Over1e	.a			10d. Inside City Limits  1 Yes 2 No
th the Maryland 23a or 28a-f show notified at once.	10e. Street and Number 612 E1mwood 1	Road	deat Sussia U.S. La	10f. Zip Code	21206		Og. Citizen of What Co	ates
after death with 1 rall", or items 23s liner must be not by Funeral		Armed Ford  Armed Ford  Yes  Vorced If Yes, Give Year  or Dates:	ces?	If Yes, specify Cub	an, Mexican, Puer	to Rican, etc.)	White, etc.  Specify:	rican Indian, Black, Black
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene.  Int: If item 27 is marked rather than "natural", or items 23a or 28a-faho ir inther traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	15. Decedent's Education (Sp. Elementary/Secondary (0-12 12 Years	College (1-4	or 5+)	cedent's Usual Occuping most of working li	fe. DO NOT use re	etired)	16b. Kind of Business United S Post Off	tatés
21215-0036 total be filed within 7 d Mental Hygiene. is marked rither than tite event, the Medica TO Be Comple	17. Father's Name (First, Middle  Warfield G.  19a. Informant's Name/Relation	. ,	19b. M	Mailing Address (Str	Arn	ne (First, Middle, I ita N. S r Rural Route Nun	,	e, Zip Code)
e, MD (1 and 2 shown Health and 1 item 27 is reframmatic	Mrs. Rebecca	J. Curry (Wi	fe) 6.	12 E1mwood Disposition (Name of or other place)	Road 0			21206
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed withi Department of Health and Mental Hygiene. Important: If iten 27 is marked nither ti injury ar other traumatic event, the Med	1 X Burial 2 Crematio 4 Denation 5 Other S 21. onatule Funeral Servi	pecify:	Clate	anislaus C 22. Name and Addre	ss of Facility	2/7/2011	Baltimo of Dundalk,	re, Maryland
Physician /Medical	23a. Part I. Enter the disease, o failure. List only one cause	on each line.	1	7922 Winter the mode of dyin	se Ave. g, such as cardiad	Dundalk or respiratory arm	Maryland est, shock, or heart	Inc. 21222 Approximate Interval Between Onset and Death
Examiner	Immediate Cause (Final diseas or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	Due to (or as a co		Alveolal	riotein	0515		
50,  be executed  ysician and  burial - transit  ledical Examiner	events resulting in death) Last  INPENDED	d.  AMENDED 2	,23a,27 pe	r me g914	4-15-11	vt		
Division of Vital Records, P.O. Box 68760, In the Bospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. In the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transiedical Certification: To Be Completed by Physician/Medical E	IF FEMALE: 23b. Was decedent pregnant in topast 12 months?	23c. If yes, ou	tcome of pregnancy		Ectopic pregi		23d. Date of delive Month	ry Day Year
s, P.O. uires that the signed by t Id be detache	Part II. Other significant condi	tions contributing to d	eath but not resulting in	the underlying cause	given in Part I.	1 Yes	bacco use contribute to	obably 4 🗹 Unknown
tal Records, clan: The law requires certificate has been signetor, page 2 should be Be Completed	25. Was case referred to medical			26 Pla	ce of Death (Chec	1 <b>✓</b> Yes	esy prior to rmed? death?	utopsy findings available completion of cause of
Division of Vital Records, P.O. Ful or Attending Physician: The law requires that the rs after death.  11 Director: After this certificate has been signed by led in by the funeral director, page 2 should be detactly ertification: To Be Completed by P	examiner?  1  Yes 2 No  27. Manner of Death	tte seitel:	Injury 28b, Tim	atient 3 DOA ne of Injury 28c. In	Othor	sing Home 5	Residence 6 Other	er.
Division o spital or Attending hours after death.  meral Director: Aft, y filled in by the fune Certification:	3 Suicide 6 Cou	rmined (Specify)	of Injury - At home, farm			or Town, S	itate)	ural Route Number, City
Tn the Howithin 24 Properties of the Function of the Medical		hysician: To the best of miner:On the basis of e and manner states	examination and/or inve	stigation, in my opinio				he cause(s)
	30. Name and address of person	115	of leath (Item 23a)	0.0	.M.E.		February 4, 201	
ØV.	Zabiullah Ali, M.D.	Assistant Medical	Examiner 900 \		eet, Baltimore	e, MD 21223		
State Registrar	31. Date the HM HH Day Near	Angua 32. Regis	strar Signature	1				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Joseph Clayton Clemons Month Feb. Day 2011 8:15 P M 3 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Timonium Stella Maris Hospice Center Baltimore Co. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral (Month, Day, Year) ine 9,1955 1 M 2 1 Months Days Hours Min 217-64-0050 Maryland Director 55 June Usual Residence of Decedent show or 28a-f shov notified at 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Dunda1k 1 ☐ Yes 2 🖾 No MD Baltimore 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be 1 Funeral Apt. C 2902 Liberty Parkway United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 21215-0036 Year or Dates. Vietnam 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Bottling Company 12 Years Packer Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Helen Stout Samuel G. Clemons, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2427 Rt 204 Selinsgrove, PA 17870 Faith Armstrong-Toms (Niece) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Garrison Forest V.A. Cem. 2/11/11 Owings Mills, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Duda-Ruck Funeral Home of Dundalk, Dundalk, Maryland 21222 7922 Wise Ave. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart allure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician. disease or condition resulting in death) SPINDLE CELL CANCER Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) as the burial-transi Jause (Disease or imjury and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Completed by Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy ctopic pregnancy her (specify) is certificate has been signed by the director, page 2 should be detached rlying cause given in Part I.

After this certificate

within 24 hours after deatl To the Funeral Director.

8:15

FEBRUARY

JOSEPH CLEMON

Be မ Certificate:

25. Was case referred to medical

31. Date filed (Month, Day, Year)

examiner?

1 Yes 2 X No

27 Manner of Death

in the past 12 months?  1 Yes 2 No 9 Unknown	1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3
art II. Other significant conditio	ns contributing to death but not resulting in	the unde

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JUNECIA WHITE, CRNP

	10	23d. Date of de	elivery	
		Month	Day	Year
i	23e. Did tobacco u	se contribute t	o the cause	of death?
	1 ☐ Yes 2 i	□ No 3 □ F	Probably 4	X Unknown
	24a. Was an autopsy performed? 1 ☐ Yes 2 🛣 No	death?	utopsy findir completion es 2  No	of cause of
on	ly one)			
me	5 Residence 6	X Other (Spe	cify) HOS	SPICE

28d. Describe how injury occurred

TIMONIUM, MD 21093

1 X Natural 2 Accident 3 Suicide	5 Pending Investigation 6 Could not be	(Month, Day, Year)	injury M	work?		od. Describe	now injury occurred			
4 Homicide	determined	28e. Place of Injury - At he building, etc. (Specify		ctory, office	2	28f. Location (Street and Number or Rural Route Number, City or Town, State)				
(Check 2	Medical Examine	r: On the basis of examinatio	n and/or investigation	n, in my opinion, death	occurred at t	he time, date	ause(s) and manner as stated. and place, and due to the cause(s) and mann he cause(s) and manner as stated.	er stated		
29b. Signature and tit	tle of certifier	7, "/-		29c. License number	r		29d. Date signed (Month, Day, Year)			
Jun	ecia l	Vhite C	RNP	R127	747	4	02/04/11			

2300 DULANEY VALLEY RD.

26. Place of Death (Check

28c. Injury at

4 Nursing Ho

2+1V

State Registrar

Medical

32. Registrar's Signature

28a. Date of injury (Month, Day, Year)

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28b. Time of

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January 30, 2017 8:15 А.м Charles Edward Crouse Medical 4c. County of Death Harford 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Bel Air 611 Evergreen Road Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** August 29, 1951 1**X** M 2 □ F Months Days Hours Min. 59 Maryland 219-58-5272 **Director** Usual Residence of Decedent "natural", or items 23a or 28a-f shov edical Examiner must be notified at 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director 1 Tes 2XXNo Bel Air Harford Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21014 United States 611 Evergreen Road 12. Was Decedent Ever in U.S. Armed Forces 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by 1 Tes 2 No Specify. Specify: White 3 Widowed 4 Divorced Year or Dates event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Construction Superintendent Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) ပ Charles Edward Hughes June Bowels 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Heat.
Important if item 27 any injury or other 611 Evergreen Road, Bel Air, Maryland, 21014 Mrs. Charlotte R.C. Crouse (Spouse) 20a. Method of Disposition 20b. Place of Disposition (Name of Evants, afinator of other place) Chapel - Bel Air February 1 Durial 2 X Cremation 3 D Removal from State 4 Donation 5 Other (Specify) 2011 Forest Hill, Maryland Testerment 22. Name and Address of Facility (M01543) Evans Funeral Chapel & Cremation Service-BelAir (M01543) Newport Drive Forest Hill, Maryland 21050 Jeffrey R. 21. Signature of Funeral Service License 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ LIVER disease or condition Medical resulting in death) Due to (or as a consequence of) years Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director: name 2 should he defined of the completed of the signed of Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 1 ☐ Yes ∠ ☐ 9 ☐ Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 Yes 2 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 2 No 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, determined

Division of Vital Records,

Baltimore, Maryland 21215-0036

Box 68760

P.0.

101 State

Registrar DHMH 17 Rev 7/2009

Medical

29a. Certifier

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

ANITA NAIK, D.O.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

602 S. ATWOOD

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

H0060805

DR. BEL AIR, M. D. 21014

29d. Date signed (Month, Day, Year)

1-31-11

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 8 per fh 9912 2-25-11 yt State of Maryland Poepartment of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician/ 12:35 AM Darcy Pinheiro Diniz Februari 2011 Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number 4c. County of Death Examiner Anne Arundel 1575 Millersville Road Millersville 8. Date of Birth **Fe/h**ooth, Day, **March** 2 9. Birthplace (State or Foreign Country) Brazil Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 D F Months Hours 460-58-8414 Director Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b County 10c. City, Town or Location death with the Maryland Ħ Director notified 1 Yes 2 X No Millersville MD Anne Arundel 10f. Zip Code 10g. Citizen of What Country? ō 10e Street and Number Examiner must be 23a Funeral 1575 Millersville Road 21108 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 XNo 0 2 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates Specify: Caucasian 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Cellege (1-4 or 5+) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) architect self-employed Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Department of Health and Menta Important: If item 27 is marked any injury or other treasures. ၉ Paulo Diniz Juracy Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1575 Millersville Road, Millersville MD 21108 Shawn Diniz / SON 20c. Location - City or Town, State 20a, Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 Burial 2X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory INC. Feb 8, 2011 Baltimore, Maryland 22. Name and Address of Facility Signature Cremation Society Of Maryland INC Patrik Fleming Frederick Road, Baltimore, MD 21228 sectime death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Part 1. Enter the disease, or complications that car shock, or heart failure. List only one cause on each Immediate Cause (Final Physician/ ongestive disease or condition resulting in death) Medical Due to or s a consequence of): Examiner Esquentially liet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Stroke The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last physician a sthe burial-t Physician/Medical Box 68760 attending ph IE EEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months? Month Day Year Pregnant at time of death Unknown Yes 2 No ed by the a detached f 9 Unknown Division of Vital Records, P.O. signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown as been signal as a should be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a Was an autopsy has performed page aortic certificate Yes 2 No Hospital or Attending Physician: director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) ဨ After this 28c. Injury at 27. Manuer of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: Natural 5 Pending thin 24 hours after death.

the Funeral Director: After impleted filled in by the fun 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier 2 Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Medical Examiner: On the basis of examination and/or investigation, in my online, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one) 29b. Signature and title 29d. Date signed (Month, Day, Year, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D Annamolis alelel hristie 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND ITEM#5perFH, C912, 2/8/2011, WS
State of Maryland / Department of Health and Mental Hygiene
amend #19a Per FH C912, 2/15/2014 In JH
Registrar AMEND ITEM#5perFH, G925, 3/9/12, WS Certificate of Death JH
Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Dunford Elizabeth 2011 1:30a M 02 02 Garnette /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Manor Care Nursing Towson Home Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 215-22-<del>3466</del>-3446 **Funeral** Months Days Hours Min. 1 □ M 2 ¶ Yrs. 07 01 VΑ Director 96 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County Show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 X No Reisterstown Baltimore Director MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21136 7 Marone Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Black à 3 ☑ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Private Seamstress 12th grade na permit. Pages 1 and 2 should be file Department of Health and Mental Hyg Important: If item 27 is marter any injury and i 18. Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) Be Louise Veney မှ Christopher Blackwell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Boyd-Niece Marone Ct., Reisterstown, Md 21136 Ella R.-20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Surial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2/10/2011 Owings Mills, Garrison Forest 21. Signature of Funeral Service License 22. Name and Address of Facility March F/H West Md 21215 4300 Wabash Ave, Baltimore, de Approximate Interval Between Onset and Death Do not enter the maje of dying, such as cardiac or respiratory arrest, Part1. Enter the disease, or complications, or heart failure. List only one That caused the death. one cause on Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical ue to for a consequence of) **Examiner** Sequentially list conditions, in any, leading to initional cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ue to for as a consequence of Examiner The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the huria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ned by the a ☐ Yes 2 ☐ No 9 Unknown s been signed to should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s has autopsy performed? certificate 1□ Yes 12□ N Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director After this certific completely filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 1 ☐ Yes 2/ N A Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3□ DOA ဥ 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of De Medical Certification: 5 Pending investigation Injury □ Natural (Month, Day Year) 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2/4/2011 trun 30. Name and address of person who completed cause of death (Item, 23a) (Type, Print) sien +101 shia 1006 to me 32. Registrar's Signature 31. Date filed (Month Day, Year) State Registrar Soul

DHMH 17 Rev 1/2001

11-01013 Glenn Deitz

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar				Certific	ate of	Death			F	Reg. No.		
Physicia	n/	1. Decedent's Name (								2	2. Date of Dea Month	Day Ye	ear	3. Time of Death
Medical Examir			enn De							-10#	February		. of Dooth	1750 hrs
		4a. Facility Name (if n 5755 Cedar L						4b. City, Town, or Location of Death  Columbia				4c. County of Death  Montgomery		
Funeral		5. Social Security Nur	mber	Months Dave House Min							(Y) 9. Birt Foreig	thplace (State or in		
Director		218-04-95	48	1 M 2 F		30	Yrs.	WIOTHIS	ays Hours	S IVIIII.	06/25	/1980	Co	untry) MD
,	Ī	Usual Residence of D 10a. State 10	ecedent b. County		110	c. City, Town	or Locatio	nn						10d. Inside City Limits
ow any		MD	Howai	rđ	l'°			 tsvill	2					1 Yes 2 No
yland n-f sh	흱	10e. Street and Numb					1	10f. Zip Code		_		10g. Citizen of V	Vhat Cour	ntrv?
or 28	Director			derick Ro				211					SA	•
eath with the Maryland items 23a or 28a-f show		11. Marital Status	a rie	12. Was De		er in U.S.	13. Was	Decedent of I		gin? (Spe	cify Yes or N			ican Indian, Black,
inst b	Funeral	1 Never Married	2 Ma	arried Armed F	orces?	No	If Ye	s, specify Cub	an, Mexicar	i, Puerto R	tican, etc.)	Whi	ite, etc.	
after o	by F	3 Widowed	4 Dive	orced If Yes, Give Ye		110	1	Yes 2 🔀 I	lo s <i>pecify</i>	:		Specify	: Wh	ite
nours autur	Pa	15. Decedent's Educ						's Usual Occup st of working I				16b. Kind of E	Business/I	Industry
36 n 72 h	Completed	Elementary/Second	dary (0-12)	College (	1-4 or 5+)		Meat	: Cutte	r			Giant	Food	
5-003 ed withir tygiene. other th	E	17. Father's Name (Fi	rst Middle	Last)			11000	- Cacco		r's Name (I	First, Middle,	Maiden Surnam		
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than ic event, the Medical	Be	Glenn R.		· ·							a Klom			
213 buld b il Men ic eve		19a. Informant's Name	e/Relations	nip (Type, Print )								mber, City or To		
MD d 2 sho tth and n 27 is	- 1	M/M Glenn 1		itz/ pare	nts									MD 21104
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Dispos		3 Removal f	rom State		of Disposit ory or oth	tion (Name of o er place)	emetery,		Date	20c. Location	-	· ·
		4 Donation 5	_	harand .	,	Druid		re Ceme				Pikesv		
Baltimore, M permit. Pages 1 and 2 Department of Health Important: If item 2 Imjury or other fraum		21. Signature of Fune	ral Service	Licensee						and a				ly FH, Inc.
		23a. Part I. Enter the	disease or	complications that	caused the	death Dono						licott		, MD 21043 Approximate Interval
Physician Wedical	3	failure. List only	one cause	on each line.								,,		Between Onset and Death
Éxaminer	- 1	Immediate Cause (Fir or condition resulting		a. Comp			OI PI	tuitar	у руѕ	Lunct	.1011			
		Sequentially list cond	itions,	b										
		if any, leading to imm	ediate	Due to (or as	a consequ	ence of):								
	Examine	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):												
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8760, ificate be ig physici	- 1	IF FEMALE: 23b. Was decedent pro	egnant in th			of pregnancy 2	Feta	al death	Ectopi	c pregnan	Cy	23d. Date of Month		y Day Year
Box 687 e death certification attending	icia	past 12 months?	a 🗀			e of death		er (Specify)				1		
Bo ne dear the a	Physician	1 Yes 2 No		nown g Unkr		A 4 14i	_ :_ th	. dagi iza za za	a siyaa ia D		1 220 Did 9	tohooso use son	tribute to	the cause of death?
Division of Vital Records, P.O. fal or Attending Physician: The law requires that the ra after death.  To birector: After this certificate has been signed by led in by the funeral director, page 2 should be detach.	β	Part II. Other signific	ant conditi	ons contributing	o death bi	ut not resulting	g in the ur	iderlying caus	e given in P	art I.				pably 4 V Unknown
duires en sig	ted										24a. Was	an 24b.	. Were au	itopsy findings available
SOFC law re has be 2 sho	Jple		_								auto perfo	psy orm <u>ed</u> ?	prior to death?	completion of cause of
Rec The ficate	Completed						_	00.01	( D 1)	(Ob I		2No	1 🗸 Ye	es 2 No
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of V g Phys gerthi	£	1 ✓ Yes 2 27. Manner of Death	No	28a. Date	of Injury	28b.	Time of In		jury at Worl			how injury occu		
on on ath.	틸		5 Pend	ling	h, Day,Year)	·		1	Yes 2	No				
ViSi or Att fter de Direct in by 1	<u>=</u>	2 Accident 3 Suicide		tigation 28e. Pla	ce of Injury	/ - At home, fa	arm, street	t, factory, office	building, e	tc. 2	28f. Location or Town,		ber or Ru	ıral Route Number, City
Dital ours a filled filled	Certification:	4 Homicide	deter	mined (Specify	)						or rown,			
To the withing To the Company	Medical	29b. Signature and tit		and manner		ation and of a			nse number					nth, Day, Year)
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	-	30. Name and addres	s of person	who completed car	Ise of deal	h (Item 23a)			•					
AVV		Carol Allan, N	•	sistant Medical			N. Balti	more Stree	t, Baltim	ore, MD	21223			
	ate	31. Date filed (Month	Day Year)	32.	egistrar's	Signature	1			-				
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Herander Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registral Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician 5:45 PM Dorsey Alexander James /Medical 4a Eacility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner xultimore una TOSpital altimore # ( If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Min. Year) Hours Months Days 1 X M 2 □ F Director 82 219-22-9880 29 MD Usual Residence of Decedent 10a. State 10d. Inside City Limits 10b. County 10c. City, Town or Location 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, it a Medical Examinat must be notified at Director 1 TYes 2 □ No Baltimore NA 10e. Street and Number 10g. Citizen of What Country? Hent Known as: U.S.A. 21217 Funeral 1917 Gwynns Falls Parkway 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ģ Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Department of Health and Montal Hygiene.
Important: If item 27 is marked other than "na any injury or other traumatic event the second Elementary/Secondary (0-12) College (1-4or 5+) W.R. Grace 2th grade na Operator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Marie Dorsey 2 James A. Grey 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21217 1917 Gwynns Falls Parkway, Baltimore, Thelma Dorsey-Wife 20a. Method of Disposition 20c. Location - City or Town, State Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State King Memorial Park 2/4/2011 Woodlawn, Md 4 Donation 5 Other (Specify) 21. Sign vire of Funeral Service Licensee 22. Name and Address of Facility March F/H West 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Baltimore, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** avdiac HK /Medical Due to (or as a consequence of): Examiner Divation Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to lor as e consequence of): physician and s the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery Live birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 Other (specify) s been signed by the should be detached 1 ☐ Yes 2 ☐ No 9 🗀 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy certificate 2 DNo 1 Yes 1 ☐ Yes completely filled in by the funeral director, 25. Was case referred to medical examiner?

11 Yes 2 □ No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 🔀 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Natural
2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number li ansis Name and address of person who completed cause of death (Item 23a) (Type, Print) 2 vede 31. Date filed (Month, Day, Year) State B Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JANUARY 30, 2011 8:10 P M DELIA THERESA DAVIS Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death HARFORD UPPER CHESAPEAKE MEDICAL CENTER BEL AIR 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 1 F Month, Day, Year, 1910 Ireland Months Days Hours Director 219-22-0434 100 Aug. Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Harford Joppa 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 21085 USA 1109 Janice Court 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify: If Yes, Give Year or Dates Specify: 3₺ Widowed 4 Divorced White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Truck & Car and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Manufacturer Cafeteria Worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mary (nmn) Heneghan Michael (nmn) Hughes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit, Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other tra <u>John A. Davis Sr. / Son</u> Storeys Ct., Nottingham, MD 21236 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Holly Hill Mem. Gdn 2-5-11 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
HOWARD K. McComas Funeral Home, P.A.
1317 Cokesbury Road, Abingdon, Maryland 21009 Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ASPIRATION PNEUMONIA disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner BOWEL OBSTRUCTION, SM ALL BOWEL Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): ADHESTONS attending physician and for use as the burial-transi that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 4 Pregnant a Pregnant at time of death 5 Other (specify) Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by PAROXYSMAL ATRIAL 1 ☐ Yes 2 💢No 3 ☐ Probably 4 ☐ Unknown MELLITUS, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an funeral director, page 2 performed 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) မြ 1 ☐ Yes 2 ☑ No 1 X Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5  $\square$  Pending 1 Yes 2 No Investigation Hospital or Attend 24 hours after death Funeral Director; 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis or examination alroyou investigation, in my opinion, south cooling and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 29b. Signature and title of certifier Andrew Alowo leoner mo DO 2096 UTNUARY 31, 2011

2V

31. Date filed (Month, Day, Year) FEB 0 8 2011

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

FULFARD OVE. BEZAIR, MD

	Please	Type or Pri					_	_	ble.	
For State Registrar			aryland / I	•	tificate of I	Health and M Death		g. No.	1	03252
1. Decedent's Name Blaise		DeNitt	is				2. Date of Death February	√ <sup>0</sup> 6′. 20	Year	3. Time of Death 6:10 p M
4a. Facility Name (if			.13	<u>-</u>	4b. City, Town, o	r Location of Death	. obi dai j	4c. County c		0.10 p
<u>Gilchri</u>	ist Cente				Tow			Ba1	timor	<u>`e</u>
5. Social Security Nu 216-20-3 Usual Residence of	3235	9x X M 2 □ F 7. Age	(In yrs. last birt 83	hday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth ADY 11 5,	1927	9. Birthpl Count Mary	ace (State or Foreign ) land
10a. State MD	10b. County  Balti	more	10c. City, Town	or Lo					10	d. Inside City Limits  1 Yes 2 X No
10e. Street and Num 28 A11		venue, Uni	t 1904		10f. Zip Code <b>212</b>	04	10	g. Citizen of W		ry?
11. Marital Status  1  Never Marri 3  Widowed	ied 2 XMarried 4 Divorced	12. Was Decedent E Armed Forces? 1 X Yes 2 2 1 If Yes, Give 1 Year or Dates.		'	Was Decedent of F f Yes, specify Cuba ☐ Yes 2 No	ispanic Origin? (Spe an, Mexican, Puerto Specify:	cify Yes or No- Rican, etc.)		- America , White, et	
(Spec	15. Decedent's Ed		16a.	Deced (Give	lent's Usual Occup	ation during most of worki	ing 1	6b. Kind of Bus	siness Indi	ustry
Elementary/Seco	onday (0-12)	College (1-4 or 5	+)	life. D	O NOT use retired) taurante	· ·		Restau	rant	
17. Father's Name <i>(F</i> Joseph		DeNitt	is			18. Mother's Name	e (First, Middle, Ma			
19a. Informant's Na	me/Relationship (Ty					and Number or Rura		-		
20a. Method of Disp 1 Burial 2	osition	Removal from State	20b. Place of	f Dispo	sition (Name of natory or other place)	1 ,		0c. Location - 0	City or Tov	
21. Signature of Fun		.,	G. Dau			ss of Facility Ru		n Funer 21204	al Ho	ome, Inc.
	t failure. List only of Final n ditions, mediate fying injury s	b. ————	consequence of	63 k on: on:		g, such as cardiac o	1			Approximate interval Between Onset and Death
F FEMALE: 23b. Was decedent p in the past 12 m 1  Yes 2 9  Unknown	nonths?	23c. If yes, outcome of 1  Live Birth 2  Pregnant at 9  Unknown	2 🗌 Fetal death		Ectopic pregnand Other (specify)	by	_	23d. Date Mont		y Day Year
Part II. Other signification	fallur	entributing to death bu	it not resulting i	n the u	nderlying cause gi	ven in Part I.	1  Yes	2 No 3	Proba	sy findings available pletion of cause of
25. Was case referre					26. Pl	ace of Death <i>(Ch</i> ec <i>k</i>	1 Yes 2	UNO 1	☐ Yes 2	⊔ No
	TIVO	28a. Date of injury (Month, Day,	y - At home, fai	ime of njury	28c. Injur work M 1 🗌	4 □ Nursing Holy at 2 Yes 2 □ No	me 5 Residence 28d. Describe how 28f. Location (Stree City or Town, 5	injury occurred	ı	
(Check 2	<ul> <li>Medical Examination</li> <li>□ Certifying Nurs</li> </ul>	ician: To the best of ner: On the basis of exe e Practioner: To the b	ny knowledge, o amination and/o	r invest	lgation, in my opinio leath occurred at the 29c. Licenso	on, death occurred at e time, date and place e number	d due to the cause the time, date and le, and due to the ca	(s) and manner place, and due t ause(s) and man d. Date signed (	to the caus ner as stat (Month, Da	e(s) and manner stated. ed. ay, Year)
30. Name and addres	1	ompleted cause of de	ath (Item 23a) (7	Type, P	rint)	58303 Charle	5 35	Turso	NA	10

Registrar DHMH 17 Rev 7/2009

State

32. Registrar Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#1perPHYS#17perFH, G912, 2724/2011, WS
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Albert E. Dawson Sr. 2. Date of Death 3. Time of Death Month February 3 Physician/ 2011 8:55 Рм Medical 4c. County of Death Frederick 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frederick Frederick Memorial Hospital Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** (Month, Day, Year) 2/27/1928 1**x** M 2 □ F Months Davs Hours Min. Country) 196-20-9977 81 PA **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic avent. 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Director MD Frederick Frederick, MD 1 X Yes 2 □ No 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe 21701 USA 6351 Spring Ridge Parkway, Apt222 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces? US Army Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: If Yes, Give White 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Veterans Hospital Nurses Aide Be 18. Mother's Name (First, Middle, Maiden FOSCO Maiden Surname) 17. Father's Name (First, Middle, Last)

Donal
Dawson ည Donald 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10904 Farrier Road Frederick MD 21701 19a. Informant's Name/Relationship (Type, Print) Albert E. Dawson, Jr. /Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition Date 1 🗆 Burial 2 🗀 Cremation 3 🏝 Removal from State North Huntingdon, PA Penn Lincoln Mem Park 2/9/11 4 Donation 5 Other (Specify) Victor P. Doda Charles L. Stevens Funeral Home, Inc. 1501 E. Fort Ave, Baltimore MD 21230 21. Signature of Funeral Service Licensee Sic 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Ph\_sician/ Arrhythmia 1 ays disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of): attending physician and for use as the bunal-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Year Month Day Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ate has been signipage 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy Yes 2 No 1 Yes 2 No filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury 28b. Time of 28c. Injury at work? 27. Manner of Death 28d. Describe how injury occurred Certificate: Natural (Month, Day, Year) injury 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29d, Date signed (Month, Day, Year) 29b. Signature and title of certifier 0 62180 February 4 rson who completed cause of death (Item 23a) (Type, Print) 30. Name and address 400 West

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ **Robert Wayne Dust** Feb 4, 2011 8:28 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 4730 Knapp Ct. **Ellicott City** Howard 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Days XM2 DF Months 334-44-4573 Hours (Month, Day, Year) Aug 12, 1948 62 ш Director Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If fine 27 is marked other than "natures" ---any injury or other treament. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Howard **Ellicott City** 1 Yes 2 No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 4730 Knapp Ct. 21043 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces?

1 Yes 2 If Yes, Give 2 No 9/16/1973 Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 🕱 No Specify: 3 ☐ Widowed 4 ☐ Divorced 2/10/1977 Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) **Technical Director** Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Wayne Edward Dust Jean Roderick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bonnie M. Dust Wife 4730 Knapp Ct. Ellicott City, MD 21043 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place)
Crest Lawn Memorial Gardens 1 Burial 2 Cremation 3 Removal from State Feb 11, 2011 Marriottsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 21. Signature of Funeral Service Lice e 0 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician/ pancreatic carcino ma Metastatic Medical resulting in death) Due to (or as a consequence of): 31/2 years Examiner Sequentially list conditions Examiner Dusto for as a consequence of ll any leading to immedicause. Enter Underlying Cause (Disease or iinjury that initiated events the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death sate has been signed by the page 2 should be detached Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No မ 1 Yes 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural work?
1 Yes 2 No 5 Pending injury Accident Investigation the Funeral Director: npleted filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 🗌 Homicide determined within 24 hours a

To the Funeral D

completed filled in 29a. Certifier 🗜 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) D32482 2011

State

DHMH 17 Rev 7/2009

Registrar

8955 Guilford Rd., Suite 140, Columbia. MD

21046

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Alonso, M.D

D.

31. Date filed (Month, Day, Year)

FFR 0 8 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February 20ÎÎ Catherine Enright 7:30 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Sanctuary at Holy Cross Burtonsville If Under 1 Year If Under 24 Hrs. Social Security Number 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 6. Sex 7. Age (In yrs. last birthday) Days 1 M 2 X I June 7, Yan 15 West"Virginia 95 232-32-5616 Director Usual Residence of Decedent show 10b. County 10d. Inside City Limits at 10a. State 10c. City. Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland Director "natural", or items 23a or 28a-f s dical Examiner must be notified 1 ☐ Yes 2 🛛 No Maryland Burtonsville Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20866-1715 U.S.A. 3415 Greencastle Road 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Completed 3 🕅 Widowed 4 🗆 Divorced White th and Mental Hygren. 27 is marked other than "natural" Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Montgomery County College (1-4 or 5+) Elementary/Seconday (0-12) Board of Education Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Leslie Daniels Duke Mabel Newton Hendricks traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra 9033 Georgia Ave., Silver Spring, MD 20910 Roger A. Lewis (POA) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burja Cremation 3 Removal from State Elmwood Cemetery 2/11/2011 Shepherdstown, WV 4 Donation 5 Other (Specify) neral Service Lic 22. Name and Address of Facility. Melvin T. Strider Co. 310 S. Fairfax Blvd., Inc. Ranson, WV 25438 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Immediate Cause (Final Domontia Physician/ advonced disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Secretially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examin To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Day Year Pregnant at time of death signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a, Was an certificate has autopsy performed death? 2 No Yes 25. Was case referred to medical the funeral director, Be 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ☑ No ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury 5 Pending after death. 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined City or Town, State, 24 hours a Funeral I Medical Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 00069829

Registrar
DHMH 17 Rev 7/2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

Smith aveenue Bellinive MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 17 Per FH G912 2/15/2011 In State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ FEBRUARY 2011 4:20 P M MARY LEE ELMORE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Bel Air 414 Prindle Court 5. Social Securit**5 232** 240–14–<del>523</del>5 If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 F Days Min. July 24, 1918 North Carolina Hours 92 Director Usual Residence of Decedent 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at Director Maryland Harford Bel Air 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral USA 414 Prindle Ct. 21015 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces Black, White, etc. 1 Never Married 2 Married ☐ Yes 2 XNo 1 Yes 2 No Specify: Specify: White If Yes, Give 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Machine Operator Automotive Parts Co. is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental ပ Ollie (nmn) Kale Ferrell (nmn) Martin permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 414 Prindle Ct., Bel Air, Maryland 21015 Lois Buckley / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 Donafton 5 Other (Specify) Catawba UMC Cemetery 2-6-11 Catawba, NC 21. Signatur of Fune Service Icense 22 Name and Address of Facility 1 Home, P.A. Markera 1317 Cokesbury Road, Abingdon, Maryland 21009 t caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, n each line. 23a. Part 1. Enter the disease, or complicat shock, or heart failure. List only one Approximate Interval Between Immediate Cause (Final Onset and Death Due to (or to a consequence of) Physician/ disease or condition Medical resulting in death) Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events southing indeet) leads Examiner and -transit The law requires that the death certificate be executed Dementa Due to (or as a consequence of): resulting in death) Last -punialphysician the burial Physician/Medical attending pl IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ASCU O 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Iron deficing aroma 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy page performed? Yes 2 ☐ No death? 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☑ No Other: မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 🖾 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: 1 Natural 5 Pending iniury work?
1 Yes 2 No within 24 hours after death.

To the Funeral Director: Al
completed filled in by the fu 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Effertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MO 2/3/11 D31295 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kenwood Poe Balterine 701 Klorsz 5 mo 21106 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Jarka

Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Feb. **Physician** 2011 Bernice C. Fortune 12:30P M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Glen Burnie North Arundel Health Rehab Center Anne Arundel 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Aug 28 1919 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Min 188-14-6845 1 ☐ M 2 💢 F 91 Yrs. Director Pennsylvania Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow r then "netural", or Iteme 23a or 28a-f eho the Medical Examiner must be notified at MD Anne Arundel 1 ☐ Yes 2 No Glen Burnie Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21061 308 Lori Drive, Apartment C United States filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 □ Yes 2√ No If Yes, Give A Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No ģ Specify: White 3√2 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry other then Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed v
Department of Heelth and Mental Hygie.
Importent: If Item 27 is marked other it
eny injury or other treumatic event, Its
once. 4 Management Banking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Unknown Myrtle Carpenter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8 Mercer Lane, Sicklerville, NJ 08081 Suzanne Harman / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Metro Crematory Inc. | 02/07/2011 | Baltimore, Maryland 21. Signature of Funeral Service Licensee Alyson K Taylor 22. Name and Address of Facility Cremation Society of Maryland 299 Frederick Rd., Baltimore, Maryland 21228 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line, Immediate Cause (Final disease or condition resulting in death) **Physician** grain /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner physicien and the burial-transit or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) 1 ☐ Yes 2 ☑ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by cate hes been sign, page 2 should t 1 ☐ Yes 2 🗓 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed this certificate 22 No 1 ☐ Yes 2 ☐ No director, Be 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA After the 27. Manner of Death 28a. Oate of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 No i Director: / 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after d

To the Funerei Direct
completely filled in by 4 Homicide the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D-40521 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOSPITAL DRIVE 325 SUITE OCHANES 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

EB 08

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 4:30 P M Faustina Rose Frederick February Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Charlestown Care Center Catonsville Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2🛣 F Months (Month, Day, Year OV. 6, 1 Days Hours Country) Director 214-14-8746 90 Nov. MD Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Catonsville 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 719 Maiden Choice Lane HR343 21228 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 2 1 Never Married 2 Married 1 ☐ Yes 2 ☒No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 10 Sales Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Eugene Cieri Anna Gugliotta 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Frederick Daughter 5900 Great Star Drive Unit 405; Clarksville, MD 21029 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
St. John's Cemetery 2/10/2011 4 ☐ Donation 5 ☐ Other (Specify) Ellicott City, MD 2. Name and Address of Facility Sterling Ashton Schwab Witzke uneral Home of Catonsville, Inc 630 Edmondson Avenue; Catonsville, MD 21228 21. Signalure of Funeral Service Licens e Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. 23a. Part 1. Enter the disease. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician maumbni Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: f yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Box 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Hospital or Attending Physician: The law requires that the death Month 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Dementic Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No ည Nursing Home 5 Residence 6 Other (Specify) To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral di 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Gertifying Nurse Practicener: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Gertifying Nurse Practicener: To the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 61 who completed cause of death (Item 23a) (Type, Print) Maiden Choice Ln Dur pour ther 31. Dat (fill d Month, Day, Year State 0 3 2011 FEB Registrar

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11-00958 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Lonnie Eugene Ferguson State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar nt's Name (First, Middle,Last) 2 Date of Death 3. Time of Death Physician/ Month **Medical Examiner** 1958 hrs February 3, 2011 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death 1010 Stamford Road Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Days Months Hours Min Director 408-0035 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Yes 2 No MORE Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other tramantic event; the Medical Examiner must be nofified at once. Director 10f. Zip Code 10g. Citizen of What Country 11 Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14 Race - American Indian Black 12 Was Decedent Ever in U.S. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 1 Yes 3 Widowed f Yes. Give Year 1 Yes 2 No specify: 6 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+ 101 ears 18.Mother's Name (First, Middle, Be 2 3 Department o 4 Donation 5 Other Specify Services ature of Funer 21212 Approximate Interval Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dyin Physician failure. List only one cause on each line Between Onset and (Medical a. Hypertensive Atherosclerotic Cardiovascular Disease Death Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transit Physician/Medical AMENDED the attending physician ned for use as the burial -UNPENDED Records, P.O. Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Month 1 Live birth 3 Ectopic pregnancy Year Fetal death Day 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown certificate has been signed by the ector, page 2 should be detached 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. á 1 Yes 2 No 3 Probably 4 ✔ Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? ✓ Yes 2 No 1 Yes 2 No Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, of Vital æ Hospital: 1 Other Nursing Home 5 Residence 6 🗸 Other: Scene ER/Outpatient 3 DOA Inpatient 2 this 1 🗸 Yes After 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 V Natural Division 5 Pending 1 Yes 2 No within 24 hours after death To the Funeral Director: filled in by the 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f, Location (Street and Number or Rural Route Number, City 3 Suicide Could not be determined (Specify) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and litle of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. February 4, 2011 Viassel 30. Name and address of person who impleted cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001 OCME 2006

State Registrar

OCME

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		•	State Registrar		Cer	tificate of E	Death		Reg. No.	1 1132/0
	Physicia	n/	Decedent's Name (First, Middle, La.	·				2. Date of Dea		3. Time of Death
	Medic	al	Virginia  4a. Facility Name (if not institution, give	H •		Fleet	Location of Death		4c. County o	Year 6:01 AM
)	Examin	er	Union Memoria			Baltin			46. County o	n Deam
	Funeral		<ol><li>Social Security Number 6. S</li></ol>	ex 7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day		Birthplace (State or Foreign Country)
П	Director		216 <b>-</b> 20 <b>-</b> 9641	□M2XIF 87	Yrs.	Worth's Days	Hours Will.	12 15		NC
	nd thow at	'n	Usual Residence of Decedent  10a. State 10b. County	10c. C	ity, Town or Lo	cation				10d. Inside City Limits
	faryla Ba-f s tified	ect	MD NA		Balti	more				1 🛣Yes 2 ☐ No
	the N	٥	10e. Street and Number		····	10f. Zip Code			10g. Citizen of Wh	hat Country?
	h with ns 23a nust 1	Funeral Director	412 East Colds				212			S.A.
	r deat		<ul><li>11. Marital Status</li><li>1 ☐ Never Married</li><li>2 ☐ Married</li></ul>	12. Was Decedent Ever in U Armed Forces?		Was Decedent of Hi f Yes, specify Cuba	ispanic Origin? (Sp <sub>I</sub> n, Mexican, Puerto	ecify Yes or No- Rican, etc.)		- American Indian, , White, etc.
920	s after ral", o Exam	q p	3 ★ Widowed 4 Divorced	1 ☐ Yes 2 ☒️No If Yes, Give Year or Dates.	1	1 ☐ Yes 2 🛛 No	Specify:		Specify:	Black
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2	hin 72 ne. <b>than '</b> ie Me	mo	Elementary/Seconday (0-12)	College (1-4 or 5+)	ife. D	ousekeer	•	ung		sity of MD
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an	ould be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "natural", or items 23a or 28a-f show marked other than "natural" and matic event, the Medical Examiner must be notified at	입	Jarvis Howard				Telsie			
Maryland 21215-0036	is a is		19a. Informant's Name/Relationship (1	ype, Print)	19b. Mailir	ng Address (Street a	and Number or Rui	ral Route Number	r, City or Town, Sta	ate, Zip Code) 21212
Σ.	1 and 2 s of Health item 27 other tra		Clevis Jackson			East Co.	ldsprin			
Baltimore,			20a. Method of Disposition  Mail Burial 2 Cremation 3	Removal from State	cemetery, cren	osition (Name of natory or other place		Date		City or Town, State
<u>=</u>	permit. Page Department of Important: If any injury or once.		4 Donation 5 Other (Special 21. Singlet) of Funeral Service Licen			Memoria			Arbutu	
Ba	permit. Departn Importa any inju		Dun 5.	Tete	4	366hwas	H West ash Ave	, Balt:	imore,	Md 21215
			23a. Part 1. Enter the disease, or com shock, or healt failure. List only o	plications that caused the dea	th. Do not ente	er the mode of dyin	g, such as cardiac	or respiratory arr	rest,	Approximate Interval Between
F	nysician/		Immediate Cause (Final disease or condition	· Congesti	e H	reart 1	Failur	ಲ		Onset and Death
	Medical Examiner		resulting in death)	Due to las a consec	_ ′	prano	Sugl	krome		
		ner	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consec		oriary	29170	M OVIN	J	
	cuted nd ransit	Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events	c						
	tificate be executed ng physician and s as the burial-transit	alE	resulting in death) Last	Due to (or as a consec	quence of):					
8760	cate b physi s the b	Medical		d						
89	ا من ي		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregn 1 \subseteq Live Birth 2 \subseteq Fe	ancy	Tetania pragnana			23d. Date	of delivery
Вох	death ne atte ed for	Physician/	in the past 12 pronths?  1  Yes 2 No	4 Pregnant at time of		Other (specify)	-y		Mont	th Day Year
o O	at the d by the etach		g Unknowh  Part II. Other significant conditions of	ontributing to death but not re	sulting in the u	inderlying cause giv	ven in Part I.	23e Did to	phacco use contrib	oute to the cause of death?
S, T	ires th signe d be d	d by	Hupertensi	200		, , ,		1 🗆 `	M	3 ☐ Probably 4 ☐ Unknown
Records,	require peen shoul	Completed	Diabetes					24a. Was		ere autopsy findings available
3ec	he lav te has age 2	mo						autop perfo	rmed? de	ior to completion of cause of eath?
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$\geq$	Physic this ce al dire	ျာ	1 ☐ Yes 2 ☒ No  27. Manner of Death	Hospital: 1  Inpatient 2	ER/Outpatier		4 ∐ Nursing H		dence 6 Other	
0	ding F h. After funer	cate	1 Natural 5 ☐ Pending 2 ☐ Accident Investigatio	(Month, Day, Year)	28b. Time of Injury	work	y at :? Yes 2 □ No	28d. Describe h	ow injury occurred	3
Division of Vital	Atten er dea ector: by the	Certificate:	3 Suicide 6 Could not to 4 Homicide determined	e 28e Place of Injury - At h		7 1 7		28f. Location (S City or Tow		or Rural Route Number,
2	ital or urs aftu ral Dir lled in									
	Hosp 24 hou Fune eted fi	Medical	(Check 2 Medical Exam		on and/or invest	tigation, in my opinio	on, death occurred a	at the time, date a	ind place, and due t	to the cause(s) and manner stated.
	To the Hospital or Attending Physician: The law requires that the death cert within 24 hours after death within 24 hours after death. To the Euneral Director: After this certificate has been signed by the attendit completed filled in by the funeral director, page 2 should be detached for use	Σ	only one) 3 L Certifying Nur 29b. Signature and title of certifier	se Practioner: To the best of n	Niowieage,	29c. License		2 (	e cause(s) and man 29d. Date signed	
	,		> ( Stay	anno	N	D	5457	7	Februa	ary 2,2011
-	31		30. Name and address of person who	completed cause of death (Ite	1201		111.		1 211	TM 2 - 12
	J		Bruce Wats 31. Date filed (Month, Day, Year)	32. Registrar's Sign	UNIO ature	n Wem	orial H	ospita	1 1211	Timore, I'W
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ William Fitch Frederick 16 7011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Deg BACTIMORE WORMINGTON MEDICAL BURNIE ANNE MER CILEN 7. Age (In vrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Hours **Director** 212-46-2793 MD 08/16/1946 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland Director 1 Yes 2 X No MD Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 567 East Park Court 21061 U.S.A. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Black White etc. þ 1 Never Married 2 XMarried 1 Yes : 2 XNo Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. d Mental Hygiene. marked other than "natural", Completed 3 Widowed 4 Divorced White Year or Dates injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Traffic State Highway Admin Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ္ဝ William John Fitch Helen Klein Page 1 and 2 should Department of Health and Important: If item 27 is m 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Glen Burnie, Maryland 21061 Mrs. Betty C. Fitch / wife 567 East Park Court, Baltimorė, 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) 02/09/2011 Glen Burnie, Maryland Glen Haven Mem. Pk. permit. Signature of Funeral Service Licenses 22. Name and Address of Facility 1 2nd Ave, SW Glen Burnie, MD Singleton Funeral & Cremation Services, P.A. 23a. Part 1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or its arraidure. List only one cause on each line. Immediate Cause (Final Onset and Death > EDGIS Physician/ disease or condition ) Medical resulting in death) PAILURE Examiner Sequentially list conditions, if any leading to in mediate cause. Enter Underlying Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) 1 ☐ Live Birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 9 ☐ Unknown in the past 12 months? Dav Year 2 □ No 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown has been signed to 2 should be 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an was autopsy performed? After this certificate har funeral director, page 2 🗌 No 1 Ves Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 2 No Other: 2 1 Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Man of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending injury 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation To the Funeral Director: completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Gertifying Nurse Prantioner: To the best of Try knowledge, death occurred at the time data and place, and due to the causage) and manner as stated 29b. Signatur 1345149 and address of person who co sted cause of death (Item 23a) (Type, Print) 19301 Hugostal

DHMH 17 Rev 7/2009

Registrar

1. Date filed (Month, Day, Ye

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32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 11:27 AM BARRY FRANTA 2011 6 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE Johns HOPKINS BAYVIEW MEDICALCENTER 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months, Days Hours Min. 3-19-1951 Birthplace (State or Foreign Country)
 MD 6. Sex 5. Social Security Number **Funeral** 1 XM 2 ☐ F 218-60-5235 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County items 23a or 28a-f show ner must be notified at Yes 2 No Baltimore Dundalk MD Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21222 105 Kent Way Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2X No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 ☐XNo Specify. Specify: White δ 3 ☐ Widowed 4 No Divorced Year or Dates: Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Anderson Industrial than Elementary/Secondary (0-12) College (1-4or 5+) Contracting permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygienn important; If Item 27 is marked other the any injury or other traumatic event, the once. Steel Worker 12 1+ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Nancy Deily Leonard Franta 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1703 Pot Spring Rd., Timonium, MD 21093 Megan Franta - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Atlantic Crematory 2-8-11 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Bradley-Ashton Funeral Home 21. Signature of Funeral Service Licenses PA, 2134 Willow Spring Road, 21222 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final SEPSI'S 10 days **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 2 MONTH FASCITIS NECROTIZING Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner The law requires that the death certificate be executed and resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 attending physician Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months? 5 ☐ Other (specify) 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ INTRAVASCULAR 4 Unknown DISSEMINATED 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed COAGULATION 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death2 1 ☐ Yes 2 ☐ No 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P this 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death in by the 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a

To the Funeral I 1 👽 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) mD FEBRUARY 6, 2011 RES-000

State Registrar Netthen

31. Date filed (Month, Day; Year) 32. Registrar's Signature EEB 0.9 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nanor MD

4940 EASTERD AVENUE BALTIMORE MD 21224

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dale M. Fletcher Month 2/5/2011 7:30am <sup>M</sup> 4c. County of Death N/A 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 1435 Andre Street Baltimore 7. Age (In yrs. last birthday) 60 yrs Social Security Number 217–48–9112 cial Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 1 XM 2 - F Days Hours 97277950 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD N/A Baltimore 1 X Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 1435 Andre Street 21230 USA 12. Was Decedent Ever in U.S.
Armed Forces?
Army
If Yes 2 No
If Yes, Give 69–72 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: White 69 - 72Specify: 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Longshoreman Shipping 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Evelyn Eschenbach Ernest M. Fletcher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailling Address (Street and Number or Rural Route Number, City or Town, State, 1326 Andre Street, Baltimore MD 21230 Megan E. Tarbutton / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)

Ardent Crematory 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 2/10/11 Hanover Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee V1CLOr P. Doda Name and Address of Facility harles L. Stevens Funeral Home, 501 East Fort Avenue, Baltimore icas 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death)

Physician/ Medical Examiner Examine

the attending physician and hed for use as the burial-transit

page

Physician/Medical

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Completed

Be

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Certificate:

Medical

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

Physician/

Medical

**Examiner** 

**Funeral** 

Director

28a - f shov

ral", or items 23a or 28a-fs Examiner must be notified

er than "natural", the Medical Exa

filed within 72 tal Hygiene.

permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, I

Director

Funeral

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death with the Maryland

Baltimore, Maryland 21215-0036

Dequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last

	a.	ACUTE MYDEARDIAL INFA
•		Due to (or as a consequence of):
	t.	ANASARCA
		Due to (or as a consequence of):
	c.	LIVER CHERHOSIS
		Due to (or as a consequence of):
	d.	

IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Pregnant at time of death 2 No 9 Linknown 9 Linknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. COHOLISM

Hospital

23e. Did tobacco us	se contribute to the cause of death?
1 ☐ Yes 2 🕻	No 3 Probably 4 Unknown
24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?  1 □ Yes 2 □ No

23d. Date of delivery

Dav

Year

Month

25. Was case referre examiner? 1  Yes 2	
27. Manner of Death	
1 Natural	5 Pending
2 Accident	_ Investigation
3 Suicide	6 Could not be

1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28b. Time of

of person who completed cause of death (Item 23a) (Type, Print)

BA-CT

Other: 28c. Injury at work? 1 Tes 2 No

26. Place of Death (Check only one)

28d. Describ

sidence 6 Other (Specify)	
e how injury occurred	

		1
29a.	Certifier	1 Certifyi

4 Homicide

30. Name and add

6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined

ng Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. al Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28f. Location (Street and Number or Rural Route Number,

	only one)	3 L Certif	ying Nurse	Practione	r: to the
29b.	Signature ar	nd title of cer	ifier	/_	-
			an	, ce	1 1
		noul	16 30	01	TI

best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number

1 MORE

	29d. Date signed (A	Aonth, D	ay, Year)
1	CHRUARY	7,	2011

	State
Rec	istrar

31. Date filed (Month) Day, strar's Signature

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within 24 hours after death.

To the Funeral Director: A completed filled in by the fu

Ph, sician/ Medical **Examiner** the Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit Division of Vital Records, P.O. Box 68760 ettending ph the detached signed by 2 should be been has page this certificate within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director,

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Physician/

Medical

**Examiner** 

**Funeral** 

Director

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er than "natural", or items 23a o the Medical Examiner must be

permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Meritan injury or other traumatic event, the Meritan

notified at

Director

Funeral

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Completed

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the Maryland

72 hours after death

Baltimore, Maryland 21215-0036

	shock, or heart failure. Est only one cause on each line.							
e v	Immediate Cause (Final disease or condition	ACUTE STROKE				Interval Between Onset and Death		
	resulting in death)	Due to (or as a consequence of):						
		ACUTE INTRACRA	ANIAL BLEED					
amine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events	Due to (or as a consequence of):						
edical Ex	resulting in death) Last	Due to (or as a consequence of):						
Be Completed by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		1 Live Birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)					
eted by P	Part II. Other significant conditions c	ontributing to death but not resulting in the under	outing to death but not resulting in the underlying cause given in Part I.			23e. Did tobacco use contribute to the cause of death?  1  Yes 2 No 3 Probably 4 Unknown		
Comple				24a. Was an autopsy performed?	prior to death?	topsy findings available completion of cause of 2 2 No		
æ	25. Was case referred to medical examiner?		26. Place of Death (Check of	only one)				
	T les 2/15/NO	Hospital: 1 Papatient 2 ER/Outpatient 3	☐ DOA Other: 4 ☐ Nursing Hom	ne 5 🗆 Residence	6 Other (Spec	ify)		
Medical Certificate: To	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not b		work? 1 ☐ Yes 2 ☐ No	3d. Describe how inju	iry occurred			
al Cert	4 Homicide determined	28e. Place of Injury - At home, farm, street, fa building, etc. (Specify)	e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Street and Number or Rural Route Number, City or Town, State)			
Medica	only one) 3 Certifying Nurs	sician: To the best of my knowledge, death occurr iner: On the basis of examination and/or investigatio se Practioner: To the best of my knowledge, death o	<ul> <li>in my opinion, death occurred at the</li> </ul>	ne time, date and place	e and due to the o	ause(s) and manner stated		
	29b. Signature and title of certifier		29c. License number		ate signed (Month			
	<b>)</b> //		D46356	MANUS =	1.7011			

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21204

State

Registrar

7601

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

32. Registrar's Signature

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31. Date filed (Month, Day, Year)

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Examiner P.O. Box 68760 BENWA SR. Records, Division of Vital Hospital or Attending Physician;

Examiner physician and s the burial-transit the attending physician the for use as the burial Physician/Medical Completed by Be Certification: To

**Physician** 

/Medical

Examiner

**Funeral** 

Director

ral", or items 23a or 28a-f show Evan ingranget be notified at

Director

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Pages 1 and 2 should be filed within 72 hours after death with then of Health and Mental Hygiene.
ant: If item 27 Is marked other than "natural", or items 23a or:

permit. Pages 1 Department of H Important: If ite any Injury or ot

**Physician** 

/Medical

3altimore, Maryland 21215-0036

filled in by the funeral director, within 24 hours after death To the Funeral Director; Medical

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State Registrar

investigation 2 Accident 3 🗌 Suicide 6 Could not be determined 4 Homicide

29a. Certifier

(Check only one)

31. Date filed (Month, Day,

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Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie Prashanih Sanihekadur, M.D. Infectious Disease Associates PA

32. Registrar's Signature

66350

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of geath (Item 23a) (Type, Print) trashanth

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28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

N. RIDGE RD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day 1, 2011 Physician Barbara Gartside 4:16 P. M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Baltimore Charlestown Care Center Catonsville Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye. Dec. 13, Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Year. 1 ☐ M 2 🖾 F 1928 West Virginia 219-20-6779 Director 82 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinational be notified at once. Baltimore Halethorpe 1 ☐ Yes 2X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4311 Spring Avenue 21227 USA Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐Yes 2 X No Baltimore, Maryland 21215-0036 þ If Yes, Give Year or Dates: 1 ☐Yes 2XNo White Specify: 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home 12 Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John E. Longstreth Nell Cartwright ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gregory Gartside, Sr. 4311 Spring Avenue; Halethorpe, MD 21227 Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Woodlawn Cemetery 2/4/2011 Woodlawn, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke 21. Signature of Funeral Service Loon of Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Costructive disease or condition resulting in death) Kronce /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) physician and s the burial-trans resulting in death) Last Due to (or as a consequence of): Physician/Medical attending p for use as 1 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant et time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 mont Month Year Day 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No s been si should b 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? Was a autopsy performed? 24a. Was an cate has page 2 s 1 ☐Yes 2 ☐ No 1 □Yes 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

or Attending Physician: The law requires that the death certificate be executed Box 68760; Division of Vital Records, P.O. certificate director, After this nours after death.

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filled in by the funeral d the Hospital within 24 hou

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completely file

State Registrar

Certification: To

Medical

27. Manner of Death

1 Natural 2 ☐ Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

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29b. Signature and title of certifier

5 Pending investigation

6 ☐ Could not be

30. Name and address of perso

29c. License number

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

21228

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

who completed cause of death (Item 23a) (Type, Print)

28a. Date of Injury (Month, Day, Year)

and manner stated.

Maiden

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death FEBRUARY 7. Physician/ GLORIA AKERLY GAULTNEY Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore Gilchrist Hospice @ GBMC Towson If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number **Funeral** 6. Sex Age (In yrs. last birthday) Date of L. (Month, Day, 1 M 2 X F Days Min. Yrs. **Director** 85 Apr. 219-10-6617 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10b. County filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location Director Maryland Harford Joppa 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 809 Old Joppa Road 21085 USA Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Examiner Black, White, etc "natural", or þ 1 ☐ Never Married 2X Married 1 ☐ Yes 2 X No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify. Completed 3 Divorced 4 Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Jennie Leota Akerly permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic Christopher Frederick Hoffman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 809 Old Joppa Road, Joppa, Maryland 21085 Basil H. Gaultney, Sr. / Husband Baltimore, 20a. Method of Disposition
1 ♣ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 4 Donation 5 Other (Specify) Highview Memorial Gdn 2-11-11 Fallston, Maryland 21. Signature of Funeral Service Dicensee Name and Address of Facility MCComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the seath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final tomo oru Physician/ SCIENUSII disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examin sician and burial-transit that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Box 68760 the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown use 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) in the past 12 months? Month signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No page the Hospital or Attending Physician: thin 24 hours after death. the Funeral Director: After this certifical impleted filled in by the funeral director, I Be 25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) 1 Yes Other: 2 No ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 1 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred Certificate: 1 🙎 Natural 5 Pending 1 ☐ Yes 2 ☐ No Acciden
Suicide Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide completed filled in by determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3. Time of Death

9. Birthplace (State or Foreign

10d. Inside City Limits

Approximate interval Between Onset and Death

Day

Year

hospice

1 Yes 2 No

Maryland

White

7:35 A M

DHMH 17 Rev 7/2009

State

Registrar

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32. Registrar's Signature

N. Charles

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 750 Medical 4a. Facility Name (if not institution. Examiner Town, or Location of Death 4c. County of Death 5. Social Security Number 7. Age (In yrs, last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Days Hours May 30 1 □ M 2 🂢 F Director Marviand 219-32-5804 74 Usual Residence of Decedent 28a-f shov 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location Director 10d. Inside City Limits Baltimore Maryland Dundalk 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1906 Searles Road 21222 HELL 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates. Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 Divorced 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 years Administrator Paper Company æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) မ Gordon Campitelli Carmelita Bisesi 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donald L. Gue Sr. Husband 1906 Searles Road, Dundalk, Maryland Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Februärv 1 XBurial 2 Cremation 3 Removal from State Cardens of Faith Cemetery Rosedale, Maryland 4 Donation 5 Other (Specify) 2011 21. Signature of Funeral Service Licensee <sup>22. Name and Address of Facility</sup> Connelly Funeral Home of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 23a. Part 1. Enter the disease, Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Opset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been sinned by the attending abundant mod as the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 the attending IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No ģ Pregnant at time of death Month Yes should be detached 9 Unknown this certificate has been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 3 Probably 4 Unknown Yes 24a. Was an 24b. Were autopsy findings available page 2 prior to completion of cause of death?

1 Yes 2 No autopsy perforr To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Certificate: To 1 🗌 Yes npatient 2 🗌 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5  $\square$  Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signat nd title of certifier 29c. License number 29d. Date signed (Month. Day, Year) 5639 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month D Day 5 Year Physician/ 11:491 Figure leen Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death SEASONS HOSPICE @ NORTHWEST HOSPITAL BALTIMORE RANDALLSTOWN Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🛛 F 08/21/1927 **Director** PA 196-22-6728 83 Usual Residence of Decedent items 23a or 28a-f show ner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at ones. 10a. State 10b County 10d. Inside City Limits 10c. City, Town or Location Director 1 Yes 2 No MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7004 CONCORD ROAD 21208 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Force Black, White, etc. þ 1 Never Married 2 Married Yes 2 X No 3altimore, Maryland 21215-0036 ☐ Yes 2 X No Specify: Completed 3 X Widowed 4 Divorced Specify: WHITE Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ VICTOR HERBERT GIPPRICK ALLENE REVNOC 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ALLENE GUTIN / DAUGHTER 7004 CONCORD ROAD, BALTIMORE, MD 21208 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State HEBREW YOUNG MEN 02/06/2011 WOODLAWN, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Service License SOL LEVINSON & BROS., 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Ph\_sician/ Pheumonia disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Chronic Obstructive Palmonary Stage NO Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and eted filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day Year Other (specify) Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 ☐ No 3 ☐ Probably 4 🕱 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 4 □ Nursing Home 5 □ Residence 6 \ Other (Specify) Other: မ 1 🗌 Yes 2 🗓 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 5 Pending 1 Natural Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical 29a. Certifier 🛚 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆

State Registrar 29b. Signature and title of certifie

31. Date filed (Month, Day, Year,

FEB 0 5 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2835

32. Registrar's Signature

DHMH 17 Rev 7/2009

29c. License number

In Avenue

20053337

Ste 203

29d. Date signed (Month, Day, Year)

e brua!

Baltmore, Mrl

DHMH 17 Rev 7/2009

Registrar

FEB 0 8 201

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## Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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	•	for State Registrar	State of M	ai yiai k		tificate of l				. ) 1	00001	
		Decedent's Name (First, Middle, L.)	_ast)			timouto or i	-	2. Date of Dea	Reg. No.		3. Time of Death	
Physicia Medio		Constance	Anne Geor	rae				Elbruas	ry Day	Year Zoll	1448 M	
Examin		4a. Facility Name (if not institution, g	ive street and number)	- 50		4b. City, Town, o	r Location of Death	1	71	ity of Death		
4		Union Memori	al Hospit			Balti						
Funeral Director		5. Social Security Number 6. 212-58-4260	7. Ag	e (In yrs. la.:	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs, Hours Min.	8. Date of Birt (Month, Day 6 – 19 -	h y, Year)	9. Birthp Coun	place (State or Foreign etry)	
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th the Maryland 3a or 28a-f show be notified at	ţo	10a. State 10b. County		10c. City,	Town or Lo	cation				1	10d. Inside City Limits	
Mary 28a-i	irec	MD Balti	.more	Spar	rows	Point					Y Yes 2 ☐ No	
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ath with tems 23a	nue	11. Marital Status 12. Was Decedent Ever in U.S.			13 \	21219  13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)			USA	ace - Americ	on Indian	
or iter	by F	1 Never Married 2 Married	Armed Forces?					Rican, etc.)		ack, White,	etc.	
saff ral", Exa	ted	3 Widowed 4 Divorced	If Yes, Give Year or Dates.		1	1 ☐ Yes 2 No Specify:			Specia	Specify: White		
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d be finenta Menta Irked tic ev	욘	James Albert	Craft, S	Sr.			Lois A	nne St	ceel			
shoulk and N is ma		19a. Informant's Name/Relationship	(Type, Print)		19b. Mailin	ng Address (Street	and Number or Rura	al Route Number	r, City or Town,	State, Zip (	Code)	
ind 2: lealth im 27 her tr		Bruce A. Geor	ge-husbar	_			Lane, Sr	arrows				
ge 1a it of H if ite or ott		20a. Method of Disposition  1  Burial 2  Cremation 3 4  Donation 5  Other (Spe	☐ Removal from State	ce	metery, cren	sition (Name of natory or other place	ce)	Date	20c. Location	-		
permit. Page 1 and 2 should be filed within 72 h Department of Health and Mental Hygiene. Important: If item 27 is marked other than "n any injury or other traumatic event, the Medi once.				Atla		Cremat					ie, MD	
permi Depar Impor any ir		21. Signature of Funeral Service Lice	ensee		$\int_{-2}^{22}$	. Name and Addre	ss of Facility Bra	adley-	Ashton	Fun	eral Home	
		23a. Part 1. Enter the disease, or co	omplications that causer	d the death.			Willow S				Approximate	
Physician/		shock, or heart failure. List only Immediate Cause (Final	y one cause on each line		anci	C					Interval Between Onset and Death	
Medical		disease or condition resulting in death)	a. Due to (or as							_	<del></del>	
Examiner	Examiner	Sequentially list conditions,	b. ———									
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requires that the de been signed by the should be detached	/ Ph	Part II. Other significant conditions	contributing to death b	out not resu	lting in the u	nderlying cause gi	ven in Part I.	23e. Did to	bacco use cor	ntribute to th	he cause of death?	
ires tl signe Id be	d by	1 ☐ Yes 2 ☐ No 3						3 🗆 Prol	bably 4 📈 Unknown			
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ian: T artifica ctor, p	Be C	25. Was case referred to medical examiner?			1 ☐ Yes 2 【 No							
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al or A s after I Dire d in b		4  Homicide determine	building, etc		70, 10,111, 011	, , , , , , , , , , , , , , , , , , , ,		City or Tow		DOT OF THE CO	Troate Harrison,	
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director After this certificate has been signed by the attending phy completed filled in by the funeral director, page 2 should be detached for use as the	edical	29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
the H hin 24 the F mplete	Me	only one) 3 Certifying N	urse Practioner: To the			leath occurred at th	e time, date and plac					
5 년 <sup>w</sup> ifi		29b. Signature and title of certifier	· · · · · · ·			29c. Licens	e number	, :	29d. Date sign	dd (Month, I	Day, Year)	
17.1		(aver/K	WIVIS	)	20-1/75	11/2	738741	0	4/4/	1/		
10		30. Name and address of person who	Completed cause of d	eath (Item 2	zsaj (lype, P Nem	sial Ho	Spital E	Saltino	R, ME	212	18	
Stat		31. Date filed (Month, Day, Year)	32. Registra	ar's Signatu	re		, ,	2 0		,		
Dogietre	_		/ /s . J. A . M	. /20//	2 A A CARE							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 0357A M Physician Feb Ellamae George 05 2011 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Agnes Baltimore Hospital Saint | If Under 1 Year | If Under 24 Hrs. | 8, Date of Birth (Month, Day, Year Oct. 28, 1 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number Maryland **Funeral** 1 □ M 2 🕸 F 213-64-2929 58 **Director** Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location 10b. County 10a. State show th and Mental Hygiene.
7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examinat must be notified at 1√ Yes 2 No Director MD N/A Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 1215 Street 21223 James Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 White 1 ☐ Yes 2 🛛 No Specify. 3 XWidowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own home Homemaker 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elsie Wheeler Walter Smith ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5908 Lynbrook Road, Brooklyn Park MD 21225 Department of Health as Important: If item 27 is any injury or other trau Donna Clevenger-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 N Burial 2 □ Cremation 3 □ Removal from State Cedar Hill Cemetery Feb.9,2011 Brooklyn Park MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Ambrose Funeral Home of Lansdowne 2719 Hammonds Ferry Road, Lansdowne MD 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician metastatic colon Cancer year disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner OPD Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-trans Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 ☐Yes 2 ☑ No 2 🗆 No 1 □ Yes 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2 12/No 1 🗹 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier

Box 68760, Division of Vital Records, P.O. within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

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Mohammad Valikhani 31. Date filed (Month, Day, Year) FEB 08 2011

(Check only one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 32. Registrar's Signature Darke

and manner stated.

MI).

State

Registrar

29c. License number

00 69 177

Baltimore

29d. Date signed (Month, Day, Year)

05

21229

2011

Feb

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 5:11 A Martin David Gerick, Sr. February 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Towson Gilchrist Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number Funeral Age (In yrs. last birthday) April 10, Days Hours Min. 1**X** M 2 □ F 77 219-28-7322 1933 Baltimore, Maryland Director Usual Residence of Decedent : If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at ld be filed within 72 hours after death with the Maryland Mental Hygiene. 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Director **Baltimore** Parkville 1 ☐ Yes 2X No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21234 United States 8803 Wilson Avenue 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married þ 1 Yes If Yes, Giv 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White Completed 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Bethlehem Steel Executive Manager 4 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Michael Gerick Hazel Lau permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Parkville, Maryland 21234 5 Chattam Court Bernadette Harroll (daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place)

Carrison Forest Veterans

Cemetery 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State February 10, 2011 Owings Mills, Maryland 4 ☐ Donation 5 ☐ Other (Specify) . Sign 11 to +4 Funeral Sorvice Cens 22. Name and Address of Facility
Evans Funeral Chapel & Cremation Services—Parkville
8800 Harford Road Parkville, Maryland 21234 COV X 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Physician/ ma Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): cause. Enter Underlying The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last -trans and Due to (or as a consequence of) -burialattending physician I for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? 1 ☐ Yes 2 ☐ No been signed by the atte should be detached for a Day Year Month Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has autopsy performe after death.

Director, After this certificate 1 Yes 2 No To the Hospital or Attending Physician: gompleted filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) NOST VY 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 2 Accident 3 Suicide 5 Pending 1 🗌 Yes 2 🗌 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral L Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. e and title of certifier if

State Registrar 31. Date filed (Month, FEB 0 8

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ Month Lillian Monroe Hebron February 15 Medical a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death

Mitchellville Examiner 4c. County of Death  $\overrightarrow{PG}$ 11411 Lake Arbor Way #206 Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Funeral Days Min. Months Hours 1 🗆 M 2 🛛 F 579-22-2841 Director 85 05-04-1925 Wash. Usual Residence of Decedent ortant, If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Completed by Funeral Director Mitchellville MD PG Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11411 Lake Arbor Way #206 20721 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Black, White, etc. 1 Never Married 2 Married ☐ Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: If Yes, Give Specify: Black 3 X Widowed 4 Divorced Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Supervisor Government Printing of and 2 should be filed worked Health and Mental Hygi Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ James Monroe Lillian West 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph Hebron/Son 16206 Penterra Way Bowie, MD 20716 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important, If ite
any injury or oth XBurial 2 Cremation 3 Removal from State cemetery, crematory or other place) Harmony Memorial 02-10-2011 Landover, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Ronald Taylor II FH ygnature y Funeral Service Licensee 10583 Middleport In. White Plains, MD Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physiciani disease or condition Lung Cancer Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Due to (or as a consequence of): attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 D Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Pregnant at time of death 5 Other (specify) 1 Yes 249 Unknown 9 Unknown ate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2X No certificate 1 ☐ Yes 2 X No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? in 24 hours after ceau... he Funeral Director. After this ce moleted filled in by the funeral dire Other: 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DDA 4 Nursing Home 5 K Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury Natural 5 Pending work?
1 Yes 2 No ☐ Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. прleted (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 within 2 To the I only one 29b. Signature and title of cartifie 29c. License number 29d. Date signed (Month, Day, Year) D45880 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Leon Hwang 1221 Mercantile Lane, Largo, Maryland 20774 31. Date filed (Month, Day, Year) 32. Registrar's State

DHMH 17 Rev 7/2009

Registrar

FEB 0 8 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 03 2011 Virginia May Harrison ebruary 1:00 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Joseph RICHEV BALTIMORE Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 💢 F Months Days Hours 70 216-36-1494 610411940 **Director** MARVIAND Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Madical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director 1 Yes 2 □ No MD aLTIMORE 10e, Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral U.S.A. 1300 ONTIAC 21225 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Completed by 1 Never Married 2 Married Yes Baitimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: BLACK 3 Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) NURSING HOME DUSE KEEPER Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ BERTHA VIRGINIA HARDINSON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2/640 19a. Informant's Name/Relationship (Type, Print) BROTHER CHARLES H. PEAKER SR. 2204 CEDAR LANE, EDGEWOOD, MARYIAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State ZION CEMETERY 109/2011 LANSOWNE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address & Facility The DERRICK C. JONES FIH, P.A. 21. Signature of Funeral Service Licensee PARK HGTS. AVE. BALTIMORE, MARYIAND hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause of Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) mis Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying ending physician and use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause Disease or liniury that initiated events Division of Vital Records, P.O. Box 68760 Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23b. Was decedent pregnant 23d Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No been signed by the atte should be detached for Month 1 ☐ Yes 2 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by empel 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗗 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s 2 ANO 1 🔲 Yes Yes 2 4 No 25. Was case referred to medical the funeral director, 26. Place of Death (Check only one) examiner? Hospital Other: 2 🔂 No မ 1 🗌 Yes HOSPICE 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 M Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: injury 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by determined e Funeral 29a. Certifier certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one)

Registrar DHMH 17 Rev 7/2009

State

29b, Signature and title of

31. Date filed (Month, Day, Year)

FEB 08

MIN

1495,000

TAYES

32. Registrar's Signature

30. Name and address of person who completed dause of death (Item 23a) (Type, Print)

29c. License number

D 602290

inden the Bulb 4d 21201

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) . Month **Physician** /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner **Baltimore City** The Johns Hopkins Hospital 9. Birthplace (State or Foreign Country)

S, CAROLINA 8. Date of Birth (Month, Day, Year) 03-21-19 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days 1 M 2 XF 216-34-8027 **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 XYes 2 □ No Director BALTIMORE MD 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number U.S.A 21202 N. HILLMAN STREET Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S 11. Marital Status Was Decedent Armed Forces? 1 ☐ Yes 2 🔀 No 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: BLACK þ 3 Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) BALTO CITY PUBLIC Schools Elementary/Secondary (0-12) College (1-4 or 5+) EACHER'S AIDE 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be FOSTER BIGEST Alberta Buckson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) HENDRICK (DAUGHTER AVE. BALTIMORE, MD . 21202 ST. George's Sharon 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 02/14/2011 BALTIMORE, MD 1 Burial 2 Cremation 3 Removal from State GARRISON FOREST 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility VAUGHN GREENE FUNERAL SERVICES 21. Signatur Funeral S ce Lie nsee 4905 YORK ROAD. BALTO, MD. 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Sepsis disease or condition resulting in death) /Medical Due o (or as a consequence of) **Examiner** iastini Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events 15017 an Cer Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day yes 2 No 9 ☐ Unknown in the past 12 months? 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 2 No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 1 Yes 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: 1 X Inpatient Other: 4 Nursing Home 5 Residence 1 ☐ Yes 2 X No 2 ER/Outpatient 3 DOA 6 Other (Specify) ၉ 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

burial-transit certificate be executed attending physician Box 68760. as the t nse P.O. þ of Vital Records, filled in by the funeral director, Division or Attending Director: After death. after To the Hospital within 24 hours a To the Funeral C Hospital

28a-f show

permit. Pages 1 and 2 should be filed within 72 hours after death with the Mar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f s any injury or other traumatic event, the Medical Examiner must be notified

Maryland 21215-0036

Baltimore.

Certification:

1 X Natural 5 Pending investigation 2 Accident 3 Suicide

4 - Homicide

(check only one)

FEB 08

29a. Certifier

Medical

State

Registrar

6 Could not be determined

28a. Date of Injury (Month, Day Year)

and manner stated

Injury

2 🗌 No 1 🗌 Yes 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number,

City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

600 North Wolfe St, Baltimore, MD, 21287

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

211 Date filed (Month, Day, Year,

32. Registrar's Signature

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle Last) 3. Time of Death Physician/ 57AM Medical 4a. Facility Name (if not institution, give street and number) Town, or Location of Death 4c. County of Death Examiner 7more last birthday) If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Min. Hours Months **Director** Usual Residence of Decedent "natural", or items 23a or 28a-f show 10b. County 10d. Inside City Limits injury or other traumatic event, the Medical Examiner must be notified at 10a. State City, Town or Location Director 1 Yes 2 ☐ No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2121. within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 21 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than use retired) (1-4 or 5+ Elementary/Seconday (0-12) Rul Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မ ones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or F ural Route Number, City or Town, State, Zip Code aughter 20b. Place of Disposition (Name of cemetery, crematory or other) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State Donation 5 Other (Specify) 21. Signatu of Funeral Service Lie any 10 23a. Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Physician/ mente TUS Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 Live Birth 2 Fetal deat
4 Pregnant at time of death 3 Ectopic pregnancy
5 Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No Month Day Year signed by the aid be detached for 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, 2 No 3 ☐ Probably 4 ☐ Unknown Completed should t peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed autopsy page this certificate 25. Was case referred to medical completed filled in by the funeral director, 26. Place of Death (Check only one) Be examiner's Hospital Other: 1 Yes 2 No nospup မှ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred After Natural (Month, Day, Year) injury 5 Pending To the Hospital or Attendii within 24 hours after death. To the Funeral Director, A М 1 Tyes 2 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death page 12. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signa

State

DHMH 17 Rev 7/2009

Box 68760

P.O.

Division of Vital

Registrar

31. Date filed (Month, Day, Year)

5701

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Month 6:55 PM **Physician** Virginia I. Harris February 2011 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner If Under 1 Year If Under 24 Hrs.

Days Hours Min. 5. Social Security Number 6. Sex Battimore Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1□ M **3** □ F Yrs 84 Director 214-26-2777 VA Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State other traumatic event, the Medical Examiner must be notified at 1 Yes 2 □ No Director MD NA Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral Baltimore, Maryland 21215-0036 5211 Beaufort Ave 21215 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: Specify: Black à 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th grade Elevator Operator John Hopkins 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ၉ Mary Mollie Magdelene Hope Vaughn 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5211 Beaufort Ave, Baltimore, Md 21215 William Joel Harris-Son permit. Pages 1 and Department of Healt Important: If Item 2: any injury or other: 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Vet 2/11/2011 Owings Mills, Md 21. Signature of Funeral Service Licensee March Funeral Home West 4300 Wabash Ave, Baltimore, Md 21215 as Approximate Interval Between Onset and Death 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Heart **Physician** Due to (or as a consequence of) disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by of Vital Records. Fibrillation 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy 2 No certificate 25. Was case referred to medical examiner?
1 ☑ Yes 2 ☐ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred **Division** 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No ours after death.

neral Director: A
filled in by the fu 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 Homicide within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State

Registrar DHMH 17 Rev 1/2001 29b. Signature and title of certifier

and Ji

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hanson, M.D.

Belvedere

M.A.

2401 W

32. Registrar's Signature

29c. License number

D59062

Bultimore MA 21215

29d. Date signed (Month, Day, Year)

2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Felov Physician/ Year Holmes :50 AM Delores 761 break Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Randallstown Season's Hospice If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) Funeral Hours 1 🗆 M 2 🔀 F Days Vrs MD Director 219-26-7819 Usual Residence of Decedent 23a or 28a-f show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits at Director or than "natural", or items 23a or 28a-fs the Medical Examiner must be notified NA Baltimore X Yes 2 □ No MD 10e. Street and Number 10f Zin Code 10g, Citizen of What Country? Funeral U.S.A. 21215 3808 Penhurst Ave within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. ò 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes Give 1 Yes 2 No Specify: Black 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) ete-Tete Hair Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Salon Cosmetologist 12th grade na Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Beckett Harold Staley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is 3808 Penhurst Ave, Baltimore, Md 21215 Dennis Holmes-Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State X Burial 2 Cremation 3 Removal from State King Memorial Park 2/11/2011 Woodlawn, Md injury 4 Dogation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H West any rome 4300 Wabash Ave, Baltimore, Md Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shody, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ olon Cancer Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of) that the death certificate be executed the burial-transit Due to (or as a consequence of) physician Physician/Medical attending pl IF FEMALE yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy
Pregnant at time of death 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day Year Pregnant at time of death signed by the a 1 ☐ Yes 2 ☑ g ☐ Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Renal fealure 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of has autopsy performed? page death? Physician: The certificate 1 Yes funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other Specify Hospital 2 No 1 Yes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending injury work? 1 ☐ Yes 2 ☐ No Natural 5 Pending 24 hours after death. Funeral Director: A Accident Investigation the 6 Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by determined City or Town, State) Medical ( 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 only one 29b. Signature and title of 29d. Date signed (Month, Day, Year) 29c. License number 120053337 bruary Name and address of person who completed cause of death (Item 23a) (Type, Print) Smith Are Sk 203 Sean 2835 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

FEB 0 8 2011

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Harris Mont Barbara 8:15PM 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Reisterstown Cherry Wood Baltimore Care If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign . Age (In yrs. last birthday) **Funeral** (Month, Day, Year) 04211947 1 🗆 M 2 💢 F Months Days Hours Country) NC 678 Director Lisual Residence of Decedent or 28a-f show be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Kandallstown 1 Yes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? pe Funeral 23a Road 21133 Cedarhill or items within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or item ledical Examiner n 12 Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2 XNo Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed Medical 16b. Kind of Business Industry, Social Security 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Clerk Keview Administration Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Benjamin Cleag Marie Knight 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Walter Harris Husband Kandallstann 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Owings Mills, MD Forest 08 4 ☐ Donation 5 ☐ Other (Specify) FOUVISON 21. Signature of Funeral Service Licensee 22. Name and Address of Facility inerty Road Randallstown MD 21133 23a. Part 1. Enter the disease, or complications that caused shock, or hear failure. List only one cause on each line sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death DISEASE Immediate Cause (Final disease or condition resulting in death) Physician/ Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last the burial-tran and Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Year Day Pregnant at time of death be detached the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by To the Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe Yes 2 After this certificate ☐ Yes completed filled in by the funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Tyes Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work?
1 Yes 2 No 1 Hatural 5 Pending injury within 24 hours after death. To the Funeral Director: At Accident Suicide Investigation 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 6 Could not be . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical 29a. Certifier Ifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed 2011

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State Registrar 31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Feb. 04 2011 3:35A <sup>™</sup> <u>Tessie</u> Herrington Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Future Care Sandtown N.H. NΑ Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth Funeral Country) NC (Month, Day, 0-23-2 Hours Min 86 Director <u> 169-22-798</u> Usual Residence of Decedent shov 10a. State 10b. County 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director MD NA Baltimore XX Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21217 USA 1100 Gilmor Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian,
Black, White, etc. African rmed Forces? þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates <sup>Specify:</sup>American 3 XWidowed 4 ☐ Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Housewife 9th Grade Domestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Fleming Little Lannie Lonnie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5319 McCormick Avenue Baltimore,MD 21206 Carolyn R. Riley-Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Xurial 2 Cremation 3 Removal from State cemetery, crematory or other place Arbutus Mem. Pk. 02-12-11 Arbutus, MD 4 ☐ Donation 5 ☐ Other (Specify) Wylie Funeral Home P.A. 22. Name and Address of Facility 21. Signature of Funeral Service Licens. 638 N. Gilmor Street Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each the. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical as a cons ence of) Examiner Sequentially list conditions, il any, leading to in redictions. Enter Underlying Cause (Disease or iinjury bue to for as a consequence of Exami attending physician and for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav Pregnant at time of death Other (specify) ed by the a 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed peen s page 2 should Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy within 24 hours after death.

To the Funeral Director: After this certificate to completed filled in by the funeral director, page 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural Accider 5 Pending 1 Yes 2 🗌 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 6

Registrar

DHMH 17 Rev 7/2009

State

30. Name and address of person

31. Date filed (Month, Day, Year).

Herrington

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23a) (Type, Print)

eted cause of death (It

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registra Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ February 3, 2011 Barry Richard Hollingsworth 8:15 PM Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Harford Bel Air, 803 Candlelight Court, If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** June 27, 1940 Days Months Hours 1 XM 2 🗆 F Pennsylvania Director 192-30-1870 70 Usual Residence of Decedent 10d. Inside City Limits shov 10c. City, Town or Location 10b. County within 72 hours after death with the Maryland items 23a or 28a-f sho ner must be notified at Director 1 Yes 2 X No Harford Bel Air Maryland 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number Funeral USA 21014 803 Candlelight Court, 2B Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S 11. Marital Status er than "natural", or ite the Medical Examiner Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. <u>ک</u> 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) Automotive permit. Page 1 and 2 should be filed within 75 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Assembler Manufacturing 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Dorothy (unk) Masimer Richard (unk) Hollingsworth Page 1 and 2 should 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1099 N. Tollgate Road, Bel Air, Maryland 21014 Brian Hollingsworth / Son Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 Burial 2X Cremation 3 Removal from Stat 2/5/2011 Towson, Maryland Hillton Service Corp. 4 Donation 5 Other (Specify) uneral Serfice Licensee 22. Name and Address of Facility McComas Funeral Home, P.A. 21. Signatur 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ocardia Physician/ disease or condition Medical resulting in death) Due to (or Examiner Yrav CYCYIAVI Sequentially list conditions. Examine Due to (or as a cons nce of) if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death Yes signed by the a g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been si 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has t lirector, page 2 s autopsy performed 1 ☐ Yes 2 ☐ No Yes 2 Division of Vital 25. Was case referred to medica 26. Place of Death (Check only one) director, Be examiner? Hospital: Other: 4 Nursing Home 5 NResidence 6 Other (Specify) 1 Tes 2 X No 1 Inpatient 2 ER/Outpatient 3 IDOA ည To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral di 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural iniury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation 2 Accident
3 Suicide
4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 29b. Signature and title of certi 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 7/2009

State

10 V

30. Name and address of person v

31. Date filed (Month, Day, Year,

FEB 08

32. Registrar's Signature

Please Type or Print in Black Indelible ink. Ensure All Copies Are Legible.

Seaford Honeyghan		State of Maryland / Department of	of Health and Mental H	lygiene	d o i	
	R	For State Certificate C	of Death	Re 2. Date of Deat	g. No.	3. Time of Death
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ř		2013 Walbrook Avenue	Baltimore	To a series	N/	
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Maryland r 28a-f sho	}	0e. Street and Number	10f. Zip Code	10	g. Citizen of What	Country?
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and 2 Jealth 2 Jean 2 Jean 2 Jean 2 Jean 2 Jean 3 J		20a. Method of Disposition 20b. Place of Dispo	osition (Name of cemetery,	Date	20c. Location - Ci	ty or Town, State
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Baltimore, MD 2 permit. Pages 1 and 2 shoul Department of Health and M Important: Witem 27 is injury or other traumatic.			Name and Address of Facility of Broom 140 N. Fulton			
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376(ificate ificate by the b		F FEMALE:  3b. Was decedent pregnant in the 2 23c. If yes, outcome of pregnancy 1 Live birth 2 7 F	Fetal death 3 Ectopic pregr	nancy	23d. Date of de Month	Day Year
Box 68760, death certificate be the attending physical for use as the burnwelf lan/Mee	3	past 12 months?	Other (Specify)			
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Records, P.O. Box 68760, The law requires that the death certificate be teather base been signed by the attending physicipage 2 should be detached for use as the buricompleted by Physician/Med.		Cocaine Use	s underlying cause given in it are is			Probably 4 🗹 Unknown
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tal Records cian: The law requi certificate has been rector, page 2 should		25. Was case referred to medical	26.Place of Death (Chec		2 110	7 100 2 100
- S -	Ĭ	examiner?  1 • Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatie	nt 3 DOA Other Nurs	ing Home 5	Residence 6	Other: Scene
Division of Vital   To the Hospital or Attending Physician: within 24 hours after deals. To the Funeral Director: After this centific completely filled in by the funeral director.	-1	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of	· ' · · · · · · · · · · · · · · · · · ·	28d. Describe	now injury occurred	
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Division o spltal or Attending tours after death. neral Director: After filled in by the fune.		3 Suicide 6 Could not be determined (Specify)	reet, factory, office building, etc.	or Town, S		or Rural Route Number, Only
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To the Ho within 24 To the Fu complete!	3	one) 2 Medical Examiner: On the basis of examination and/or investig	gation, in my opinion, death occurred	at the time, date	and place, and due	e to the cause(s)
To vit	Ē	and manner stated.  29b. Signature and title of certifier	29c. License number			(Month, Day, Year)
	1	e I MINT	O.C.M.E.		February 1, 2	2011
ex 1	t	30. Name and address of person who completed cause of death (Item 3a)	Politimara Circat Dellines	MD 24222		
ØV		Zabiullah Ali, M.D. Assistant Medical Examiner 900 W.  31. Date filed (Monthmore Year) 32. Registrar's Signature	Daitimore Street, Baitimore	5, IVIL) 2 1 Z Z 3		
Stat	e	31. Date filed (Month, Day, Year) 32. Registrar's Signature				

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item State of Maryland 20,627 17 20 Pi Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** a600 AM Gordon H. Himmer 26 2011 an /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE HGNE. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Hours Min. 1 XM 2 ☐ F 215-18-2648 92 11-9-1918 **Director** MD Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location in than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1 XYes 2 No Director MD Baltimore Catonsville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 719 Maiden Choice Lane 21228 Funeral USA within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 Pres 2 □ No If Yes, Give Year or Dates: WWII 14 Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No <sup>Specify</sup>White Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within th and Mental Hygiene. 7 is marked other than " Elementary/Secondary (0-12) 1 2 College (1-4or 5+) Social Security Adm. Social Security Worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic ev John C. Himmer, Sr. Helen R. Herget 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Jill Himmer - Daughter 3207 Thornapple St., Chevy Chase, MD 20815
e of Disposition (Name of Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Atlantic Crematory 1-29-11 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Bradley-Ashton Funeral Home 21. Signature of Funeral Service Licensee PA, 2134 Willow Spring Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac a respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) HEMA TOMA **Physician** 8 DAYS DUB DURAL /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if the sequentially list conditions, if the sequential seq Due to (or as a consequence of): Examine its certificate has been signed by the attending physician and director, page 2 should be detached for use as the burlal-tran Due to (or as a consequence of):  $H/MMeR_s = CORDON$ Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Live birth 2 Fetal death 3 Ectopic pregnancy Month Year Day 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 K No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe this certificate 1 ☐ Yes 2 🗷 No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 □ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ပ To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dii 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification; 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 T Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 24065 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9005 CARON AVE BALTIMORE MD 21229 HOSPITAL, 31, Date filed (Mortth, Day, Year) State Registrar

DHMH 17 Rev 1/2001

11-00889 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Andre Henson State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Time of Death Month Day February 1, 2011 Medical Examiner Andre Troy Henson 1108 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 4421 Frankford Avenue 3rd Floor Baltimore N/A 5. Social Security Number 02 6. Sex If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Foreign Country) Months Days Hours Director 1 X M 11/01/1972 220-<del>20</del>-5171 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No l other than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at once. MD N/A Baltimore 10g. Citizen of What Country 10e. Street and Number 10f. Zip Code Ingleside Ave. 21215 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-11. Marital Status 14. Race - American Indian, Black 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 XNever Married 2 Married 1 Yes 3 Widowed 4 Divorced If Yes. Give Year 1 Yes 2 No specify: Specify: Black Š 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Pages 1 and 2 should be filed within 72 hent of Health and Mental Hygiene.

ant: If item 27 is marked other than ", 12th Grade unemployed 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 8 Levern Henson Joyce Washington 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, MD Joyce Henson(mother) Ingleside Ave., Baltimore, MD 21215 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State crematory or other place) Department of Crematory 02/09/11 Baltimore, MD 4 Donation 5 Other Specify. Name and Address of Eacility Wn 140 N. Fulton 21-Signature of Funeral Service Licens AVE:, Functal Home PA 1217 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line. /Medical Seizure Disorder Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical X UNPENDED x AMENDED 5 per fh, 23a,27 per me g913 3-28-11 vt attending physician or use as the bucial Box 68760 23d, Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 1 Live birth Fetal death 3 Ectopic pregnancy Month Day 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ≥ 1 Yes 2 No 3 Probably 4 Unknown Completed certificate has been ector, page 2 should 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of . death? 1 ✓ Yes 2 No 1 🗸 Yes 25. Was case referred to medical 26.Place of Death (Check only one) Be Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 🗸 Other: Scene 1 Yes

MD

Death

Year

2 No

Hospital or Atteodiog Physiciao: The law requires that the death certificate be executed Division of Vital Records, P.O.

this After 1 I Director:

Certification:

Medical

3

4

28a. Date of Injury (Month, Day, Year) 1 X Natural 5 Pending Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be Suicide Homicide

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number

30. Name and address of person who completed cause of death (Item 23a)

Donna M. Vincenti, MD Assistant Medical Examiner

OCME

31. Date filed (Month, Day, Year) State Registra

32. Registrar's Signature

ORIGINAL

28b. Time of Injury

28c. Injury at Work?

O.C.M.E.

900 W. Baltimore Street, Baltimore, MD 21223

1 Yes 2 No

28d. Describe how injury occurred

or Town, State)

28f. Location (Street and Number or Rural Route Number, City

February 2, 2011

29d. Date signed (Month, Day, Year)

27. Manner of Death

29a. Certifier 1 [

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 12:22 P. M January 30, Day 2011 Physician/ Melvin Russell Heil Medical 4a. Facility Name (if not institution, give street and number)
Stella Maris Hospice 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 5. Social Security Number If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) If Under 1 Year **Funeral** Months Days Hours Min 1 🛛 M 2 🗆 F July 19 4922 MaryTand 88 216-18-3909 Yrs. **Director** Usual Residence of Decedent 10d. Inside City Limits 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown injury or other traumatic event, the Medical Examiner must be notified at anoe. 10a. State 10c. City, Town or Location **Funeral Director** Baltimore 1 X Yes 2 No Maryland N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21214 2908 Echodale Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14 Race - American Indian 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married 1 XXes 2 No If Yes, Give Year or Dates. WWII White 1 Yes 2 XNo Specify: 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Glen L. Martin Machinist 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Heil Unknown Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 133 East Main Street Westminster, Maryland 21157 Michelle Ostrander/ Attorney 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2/3/11 Parkwood Cemetery Baltimore Maryland 22. Name and Address of Facility Leonard J. Ruck, Inc. 5305 Harford Road 21. Signature of Funeral Service Licenses Baltimore Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day Year Pregnant at time of death 2 🗌 No been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has blirector, page 2 s autopsy performe 1 ☐ Yes 2 ☐ No Yes funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital Other: မ 1 Yes No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 5 Pending injury 2 No Accident Investigation Accident Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined nto.
In 24 hour.
In 4 hour.
In 54 hour.
In 54 hour.
In 54 hour.
In 54 hour.
In 54 hour. Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the l within 2 To the F only one) 29b. Signature and title of 29d. Date signed Month, Day, Year)

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Y m In mum

who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 6:40 P M 201Î Jack Hull Island, Sr. Feb. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Parkville Oak Crest Care Center If Under 1 Year If Under 24 Hrs.

Pays Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) Birtnp... Country) **Funeral** 5029al 20114586 1 ★ M 2 □ F Months July 15 1919 91 Director 049-10-4588 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director 1 Yes 2 X No Parkville MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21234 8810 Walther Blvd. #1007 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status Armed Forces?

1 X Yes 2 No
If Yes, Give 1 Black, White, etc. ð 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give 40-45 1 ☐ Yes 2 ▼ No Specify: Specify: white Completed 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) PPG Co. Elementary/Seconday (0-12) College (1-4 or 5+) paint and Brushes Div Sales Manager n/aPage 1 and 2 should be filed with ment of Health and Mental Hygier ant: If item 27 is marked other t Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Ruth Hull Howard J. Island injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6704 Armitage Rd., New Hope, PA 18938 Elizabeth M. Island/daughter permit. Page 1 and 2 Department of Health Important: If item 2 any injury or other t Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State 2/4/11 Glen Burnie, MD Atlantic Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur Vichae J. 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley, Inc.
10 W. Padonia Rd., Timonium, MD 21093 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Preumonia, Immediate Cause (Final asperation Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Dusphagea Sequentially let conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of) that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of): Completed by Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ Box in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day the 9 Unknown P.0. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? (EF 15%) Coronary arky Cardiomyopathy 2 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, 1 Yes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an 24 hours after deatn.

Funeral Director; After this certificate has be recovered in the certificate has be recovered in the recovered for autopsy performe death? 1 ☐ Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?
1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2No Hospital: ျ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred iniury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Médical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2/3/2011 R171944 chap MISN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) G. Hade Michealle 8800 Walther Blvd, Parkville MD 21234 CKIR MSW

State

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Month 5:00 PM **Physician** 18 501 ebwany 2011 /Medical 4c. County of Death 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number) **Examiner** If Under 24 Hrs. Date of Birth (Month, Day, If Under 1 Year 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Social Security Number 6. Sex **Funeral** PHARY Hours 1 M 2 F Months Days Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c, City, Town or Location 10a. State th and Mental Hygiene. ?7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must to notified at 1 Yes 2 □ No Director KHMOVE 11/4/24 And 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21216 Completed by Funeral filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🕱 No 11. Marital Status Never Married 2☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No If Yes, Give Year or Dates Specify. 3 Widowed 4 Divorced HMERICAN 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. PO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Hmore Mother's Name (First, Middle, Majden Syrname) 17. Father's Name (First, Middle, Last, Be Pages 1 and 2 should be lee ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Informant's N.me/Relationship (Type. Print) Ellamont Department of Health a Important: If item 27 Is any injury or other trains once. AHIMORE MARYLAND 21216 VIMMIE Johnson - Mother 20b. Place of Disposition (Name of cemetery, crematory or other 20c, Location - City of Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State BAHIMOre, EtRO 12b 10, 2011 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee WAllace F 3405 W. TRANKlin 5+. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heat failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Assire Introduced (Final disease) Approximate Interval Between Onset and Death Physician hours /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a nonsequence of) Examiner that the death certificate be executed signed by the attending physician and be detached for use as the burial-tran Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Year Month Day 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Récords, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown cate has been signated by page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe After this certificate 1 ☐ Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1□Yes 2□No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 ☐ DOA 1 Inpatient Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred i or Attending Fafter death. Division 1 Natural 5 Pending investigation To the Hospital C. within 24 hours after death.
To the Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 00053849 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar Registrar's Signa

11-00543 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Edward Johnson, Sr State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day January 19, 2011 SR. В. **JOHNSON Medical Examiner** EDWARD 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Washinton Medical Center Glen Burnie Anne Arundel 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY **Funeral** 220-84-1920 Months Hours March 22, 1964 46 Director 1X M 2 F Usual Residence of Decedent 10c. City, Town or Location 10a State Pasadena Maryland Anne Arundel 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 806 205th Street 21122 U.S.A. ដ Funeral 11. Marital Status 12 Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 X Married Yes item 27 is marked other than "natural", ir traumatic event, the Medical Examiner 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: Specify: <u>چ</u> 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Self-Employed Carpenter 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Margaret Ginevan Gerald. Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 806 205th Street, Pasadena, Maryland 21122 Carol A. Johnson (Wife) 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Cedar Hill Cemetery 1 | Burial 2 | Cremation 3 | Removal from State Jan. 24,2011 Brooklyn Park, Maryland 4 Donation 5 Other Specify.

21. Signature of F I Service Lice 22. Name and Address of Facility McCully-Polyniak Funeral Home P.A. 3204 Mountain Road, Pasadena, Maryland 21122 Physician Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each fine /Medical Oxycodone Intoxication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit sician/Medical 23a,27,28a-f per me g912 2-15-11 vt X UNPENDED the attending physician ed for use as the burial AMENDED Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Month past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> 1 Yes 2 No 3 Probably 4 Unknown pleted director, page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? Com ✓ Yes 2 No 1 🗸 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other Nursing Home 5 Residence 6 Other 1 Yes No 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred Manner of Death 28c. Injury at Work? 1 Natural Pending 1 Yes 2 X No the fd 1-19-11 fd 8:10pm unknown Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be State) 806 205th St. Pasadena. found at residence determined (Specify) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b Signature and title of certifier 29c. License number O.C.M.E. January 20, 2011

2030 hrs

10d, Inside City Limits

1 Yes 2 No

Approximate Interval

Between Onset and

Death

Year

2 No

Day

9. Birthplace (State or Foreign Mary Land

Country)

White

State Registrar

**OCME 2006** 

Victor Weedn MD JD

30. Name and address of person who completed cause of death (Item 23a)

eap

Assistant Medical Examiner

32. Registras Signatur

900 W. Baltimore Street, Baltimore, MD 21223

11-00659

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

obert Francis Jac	1-	- For State	State	of Mary			rtment o tificate o			Ment	ai Hyg		Reg. No.	20	BLTSLT. A	1330	)(
Physician		t <b>egistrar</b> I. Decedent's Name (Firs	st, Middle,Las	st)		_		_			2	Date of De Month		Year	(	3. Time of Death	
Medical Examine		Robert Fra										January 2	24, 201	1 County of	Doath	0933 hrs	
	4	a. Facility Name (if not i		e street and r	number)			4b. City, Oxor	Town, or L Hill	ocation of	Deam			rince Ge		S	
Funeral		5. Social Security Number			7. Age (In	yrs. la	st birthday)		ler 1 Year	If Under	24Hrs.	8. Date of B	irth (MM/D	D/YYYY)	9. Birth	place (State or	_
Director	- 1	28-58-9425		<b>X</b> M 2 F	64		Yrs	Montl S.	ns Days	Hours	Min.	Dec. 9	19	46	Foreign Cour	ntry) <b>VA</b> .	
	L	Jsual Residence of Dece			l								,				
any			County				Town or Loca	tion								10d. Inside City Lim  1 Yes 2 XX	
Maryland 28a-f show d at once	5 1			eorges		XOI	n Hill	T =					10g. Citize	on of \Mos			
the Maryland a or 28a-f sh	<u>.</u>	10e. Street and Number 307 Corla D						10f. Zi	745				-	ted S			
		11. Marital Status		I 12 Was D	ecedent Eve	r in U	s 13 W	as Deced	ent of Hisp	anic Origi	in? (Spe	cify Yes or N				an Indian, Black,	_
items	runeral	Never Married	2 <b>XX</b> Married	Armed	Forces?				ify Cuban,					White,	etc.		
fter de l'', nr		3 Widowed 4	Divorce	1 Yes		NO	1	Yes 2	X No	specify:				Specify: <b>1</b>			
ours a	<u> </u>	15. Decedent's Educati				ted)	16a. Decede		Occupation				16b. Ki	ind of Bus	iness/In	dustry	
7 3 7	Diete	Elementary/Secondary	y (0-12)	College	(1-4 or 5+)		Brickl	auon					Con	struc	tio	n	
215-0036 be filed within 72 hours mital Hygiene. rked onther than "naturent, the Medical Exam	Completed	17. Father's Name (First	. Middle, Last	t)			BUCK	uget	1	8. Mother's	s Name (	First, Middle					_
1215. Id be filed Mental Hy narked ut event, th	9	Lewis Hall	,	•							ce R						
MD 21215-0036 12 should be filed within 7 th and Mental Hygene. 127 is marked rither than umatic event, the Medica	0	19a. Informant's Name/R					1.9					ral Route Nu	_				
MD 2 sh old		Carolyn Jack 20a. Method of Dispositi		ise		20h E	312 K					itol f				own, State	_
Baltimore, MD 21 bernit. Pages I and 2 should Department of Health and Me impurtant: If item 27 is ma injury or other traumatite ev	- 1	1 Burial 2 C		Removal	from State	C	crematory or o	ther place	∍)				CP:	1+00	u i	rginia	
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Baltimore permit. Pages l Department of F Important: If i	ł	June D	Tibbs	الما	MO	128						-9609	Cent	er S	Т. М	anassas,	Va
Physician		23a. Part I. Enter the dis	sease, or com		caused the	death.	Do not enter	the mode	of dying, s	such as ca	ardiac or	respiratory a	rrest, sho	ck, or hea	rt	Approximate Inter Between Onset a	val
Medical. Examiner		failure. List only on Immediate Cause (Final			halation	and T	Thermal Inj	uries								Death	
zammer	1	or condition resulting in	death)	Due to (or as	a conseque	ence of	f):										
		Sequentially list condition if any, leading to immed		Due to (or a	s a conseque	ence of	f):										
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x 68760 th certificate b trending physical r use as the bu	E P	23b. Was decedent pregress 12 months?	nant in the		e birth gnant at time	e of de		etal death other (Sp		Ectopic	pregnan	icy	Ļ	Month	Da	ay Year	
Box 68760 e death certificate I the attending physe ed for use as the bh	Physician/Me	1 Yes 2 No 9	Unknow	_ [ ]	known		3 🗀 (	uner (Sp								<u>-</u>	
다 한 다 한 다 C		Part II. Other significan	nt conditions	contributing	to death bu	it not r	esulting in the	underlyir	ig cause gi	iven in Pa	rt I.			_	-	ne cause of death? ably 4 Unknow	um.
Division of Vital Records, P.O. rate or Attending Physician: The law requires that the all predeath. The rate of t	ğ M									_		24a. Wa				opsy findings availa	
ord w requass been shoul	Completed											aut	opsy formed?	pı		empletion of cause	
Rec The la cate h page 2	Ĕ											1 Yes			<b>√</b> Yes	2 No	
certifi certifi	å	25. Was case referred to examiner?		Hospital:	1	0	ED/O: testion	- a -	_	of Death (		nly one) Home 5	Resider	nce 6	Other	Scene	_
Physi er this	٥,	1 Yes 2	No		Inpatient ate of Injury		ER/Outpatier 28b. Time of			y at Work	? :	28d. Describ	e how inju	iry occurre			
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/iSic r Atte ter dea irecto	<u>[</u> 2	2 ✓ Accident 3 Suicide 6	Investiga Could no	28e P	ace of Injury	- At h	ome, farm, str	eet, facto	ry, office b	uilding, et	с.	28f. Location or Town		nd Numbe	r or Rur	al Route Number, (	City
Dital o	Certification:	4 Homicide	determin	ed (Speci			nily Home					307 Corla D	rive, Oxo				_
Division of Vital Records, P.O. Box 6876( To the Bospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  The the Voucral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the beautified.	ے او	Tollowit strij	tifying Physi	cian: To the l	est of my kr	nowled	lge, death occ and/or investig	urred at th	ne time, da	te and pla	ace, and courred at	due to the ca	iuse(s) and te and pla	d manner ce, and di	as state ue to the	d. cause(s)	
To th withir Tn th compl	Medical	one) 2 Med 29b. Signature and title		and manne	r stated.	autil 8	and or investig		9c. License							th, Day, Year)	_
	2	250. Signature and title	9	, ,,					O.C.1					uary 25	·		
	-	30. Name and address	Mutho	Ull, MI	ause of deat	h (Iten	n 23a)										
41		Pamela E. Sou					miner 90	00 W. E	Baltimore	e Street	, Baltin	nore, MD	21223				
Sta	te	31. Date filed (Month, D			Registrar's			Nel									
Registr	-		0 0 8 21	044 /		1	1 100	-									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Je wet Thomas FEDRUEM 00 4 M 20 11 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Season's Hospice Randallstown Social Security Number 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth
(Month, Day, Year)
Dec. 13, Birthplace (State or Foreign Country) **Funeral** 937 Director 289-30-0495 Ohio Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location at Director notified MD Baltimore Catonsville 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò er than "natural", or items 23a on the Medical Examiner must be Funeral 21228 USA with 1 318 Osborne Avenue hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 🖾 No Black, White, etc 1 Never Married 2 Married þ Specify: White Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other than Manager Vending Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If Item 27 is marked o any injury or other traumatic eve once. ည Marie Sullivan Charles Foster Jewett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 318 Osborne Avenue; Catonsville, MD 21228 Carolyn Jewett Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Buriai 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Crest Lawn Mem. Park 2/9/2011 Marriottsville, MD 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 21 Signature of Funeral Gervice Lic-23a. Part 1. Enter the disease or complications that cadsed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between ENd-Stage COPD Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) anding physician and use as the burial-transi Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No for Pregnant at time of death Other (specify) signed by the a of be detached for 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Records, Completed been si 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has be completed filled in by the funeral director, page 2 sl autopsy perform Yes 2 No 1 Yes 2 No 25. Was case referred to medical **Division of Vital** 26. Place of Death (Check only one) Be examiner' Other: 4 Nursing Home 5 Residence 6 Nother (Specify) 1 ☐ Yes 2 ☐ No Hospital 1 Inpatient 2 ER/Outpatient 3 DOA မှ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

State Registrar

4

29b. Signature and title of certifier

31. Date filed (Month, Day, Year,

**FFR 08** 

nskijapahu M.O

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N-5-200-Baltimore, MD. 2(765)

D0057465

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland /		rtment of F			2.0	<b>Garage State</b>	03302
			Registrar  1. Decedent's Name (First, Middle, Last)	Cert	meate or E	JCati i	2. Date of De	Reg. No.	1 1	3. Time of Death
	Physicia			anowi	ck		JAN.	30°, 2	0 I I	11:27P.M
	Medic Examin		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or	Location of Death			y of Death	
1	<u>£</u> ,		The Dove House		Westmin			Carr	011	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last bit	rthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir	1933	9. Birthp Count	olace (State or Foreign try) MD
ı	Director		216-30-7229   TAM 2 10 F   77	115.			July 7	1933		PID .
	and show at	or	10a. State 10b. County 10c. City, Tov	wn or Loca	ation				1	0d. Inside City Limits
	Maryla 28a-f	rect	MD Carroll West	minst	ter					1 ☐ Yes 2 🛣 No
	a or 2	al D	10e. Street and Number		10f. Zip Code	1157		10g. Citizen of	What Cour	itry?
	within 72 hours after death with the Maryland glene. et than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at the Medical Examiner must be notified at	Funeral Director	208 Garden Way	Lione			if - Ve Ne			
	or iter	by Fu	11. Marital Status  1 □ Never Married 2 ☒ Married  12. Was Decedent Ever in U.S. Armed Forces?  1 ☒ Yes 2 □ No	13. VV	Yes, specify Cuba	ispanic Origin? (Sp n, Mexican, Puerto	Rican, etc.)	Bla	ce - Americ ack, White,	etc.
9500-c	s afte ral", ( Exaդ	ed b	3 Widowed 4 Divorced If Yes, Give Year or Dates.	1	Yes 2 X No	Specify:		Specif	y. Whit	e
ဂ ဂ	2 hour	Completed	15. Decedent's Education 16. (Specify only highest grade completed)	a. Decede	ent's Usual Occup	ation during most of wor	king	16b. Kind of I	Business Inc	dustry
[2]	hin 7, ne. <b>than</b> se Me	om	Elementary/Seconday (0-12) College (1-4 or 5+)	life. DO	NOT use retired)			Home I	mnrot	romant
	filed wil al Hygie d other event, th	Be (	12	Con	struction	18. Mother's Nar	ne (First, Middle,			ement
Ö	be fill ental 'ked c	일	James S. Janowick			Maude Es			,	
	should and Me is mar raumati		19a. Informant's Name/Relationship (Type, Print) 19	9b. Mailing	g Address (Street	and Number or Ru	ral Route Numbe	er, City or Town,	State, Zip 0	Code)
	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mentell Hygiene.  if health and Mentell Hygiene, interms 23a or 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		Cecilia Janowick Wife 2	08 G	arden Wa	y; Westm	inster,	MD 2115	7	
saitimore,	e 1 ar t of H If iter or oth		1 X Burial 2 Compation 2 Demous from State   cemet	tery, cremi	ition (Name of atory or other plac	ce)	Date	20c. Location	-	
	t. Page tment o rtant: If ijury or		4 □ Donation 5 □ Other (Specify) New C	atheo	dral Ceme	etery 2/5	5/2011	Baltimo	re, M	D Wirzke
g Q	permit. Page 1 a Department of B Important: If its any injury or of	. 3	21. Signature of Funeral Servic, Licensee	Fu:	Name and Addre	ss of Facility Stome me of Ca dson Ave	tonsvil	le, Iņc	MT	21220
	_		23a. Part 1. Enter the disease, or complications that caused the death. Do						e, MI	Approximate
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	Examiner	L	Survey Holly Kill and Bloom							
	n #	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	e of):						
D.	ecuter and -trans	xan	Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence	e of):					-	
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200	ficate g phys		_ a						1 1	
200	ending use a	an/N	IF FEMALE: 23b. Was decedent pregnant   23c. If yes, outcome of pregnancy   1	ath 3 🗆	Ectopic pregnance	cv			ate of deliv	
X POX	death he attr ed for	Physician/Me	in the past 12 months?  1   Yes   2   No   4   Pregnant at time of death   9   Unknown   9   Unknown		Other (specify) _			N	lonth	Day Year
j.	at the d by tl	Phy	Part II. Other significant conditions contributing to death but not resulting	g in the ur	nderlying cause gi	ven in Part I.	23e. Did 1	obacco use cor	ntribute to t	ne cause of death?
ν <sub>υ</sub>	res th signe	d by	,		, ,		1 🗆	Yes 2 ☐ No	3 🗀 Pro	bably 4 Unknown
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ပ္	e law e has ge 2	Completed						ormed?	death?	mpletion of cause of
<u> </u>	an; Tł tificat tor, pa	Be C	25. Was case referred to medical		26. P	ace of Death (Che		2 by No	T LI Tes	2 13 110
VIta	nysici nis cer I direc	To B	examiner?  1  Yes 2 No Hospital:  1  Inpatient 2 ER/C	Outpatient	t 3 □ DOA Oth	er: 4  Nursing F	lome 5 🗆 Resi	dence 6 Ot	her (Specif)	, Hospice
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loi O	ttendi death tor: A the fu	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home,	form atra		Yes 2 No	20f Leasting /	Street and Num	har ar Pura	I Route Number,
DIVISION	l or Al after Direc I in by	Cerl	4 Homicide determined building, etc. (Specify)	iarm, stre	et, factory, office		City or To		per or nura	r noute Number,
ב	To the Hospital or Attending Physician: The law 'equires that the death certificate within 24 hours after death.  within 24 hours after death.  completed filled in by the funeral director, page 2 should be detached for use as the	edical	29a. Certifier 1 certifying Physician: To the best of my knowledge	e, death o	ccured at the time	, date and place, a	and due to the ca	ause(s) and mar	ner as state	ed.
	he Ho in 24 I he Fu pleted	Med	(Check 2 Medical Examiner: On the basis of examination and only one) 3 Certifying Nurse Practioner: To the best of my kno	l/or investi wledge, d	gation, in my opini- eath occurred at th	on, death occurred e time, date and pla	at the time, date ace, and due to th	and place, and c ne cause(s) and t	nanner as si	use(s) and manner stated.
	Voith com		29b. Signature and title of certifier		29c. Licens			29d. Date sign	ed (Month,	Day, Year)
	1.1		Kiklettalace my, m			064593		21	1/11	/ 
	511	(	50. Name and address of person who completed cause of death (Item 23a)			DESTAIL	15ton 1	ווכ מ	57	
	Stat	te	31. Date filed (Month, Day Year) 32. Registra's Signature		א גשווע	ווריקונטייי	TOIG !	Anorth	<u> </u>	
	Registra		TEBUOZUIT Denun D. gan	Ke						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Year Month Physician/ lan Medical 4c County of Death 4a. Facility Name (if not institution, give street and number **Examiner** orthuces HOSM 1 くひ 8. Date of Birth (Month, Day: 9. Birthplace (State or Foreign Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Min. Country) Months 1 X M 2 □ F Hours 220. FO. 0195 **Director** Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Director Baltimore Randallstown 1 Yes 2 No 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Koad, Apt. 203 21133 Funeral tvine death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after d Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or i any injury or other traumatic event, the Medical Examin, once. 1 Never Married 2 Married ò Maryland 21215-0036 1 Yes 2 No Specify: Black If Yes Give Completed 3 Widowed 4 Divorced Year or Dates. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry College (1-4 or 5+) Elementary/Seconday (0-12) State of Maryland Officer Police 12th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) **H**. Mary Miles Jackson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21133 19a. Informant's Name/Relationship (Type, Print) Kandallstown, MD Jacksin Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place)
WOODIGWN CEMETE 1 Burial 2 Cremation 3 Removal from State Woodlawn, MD 2011 4 ☐ Donation 5 ☐ Other (Specify) ann C. Epsene Funeral Services Signature of Funeral Service Licensee Randall stown MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or a a consequence of) **Examiner** Sequentially list conditions, Examiner Due to (or as a consequence or) cause. Enter Underlying Cause (Disease or linjury the Hospital or Attending Physician: The law requires that the death certificate be executed ending physician and use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 the attending IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year for Month Day Pregnant at time of death 5 Other (specify) Yes 2 No been signed by the sahould be detached if g 🔲 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 Probably 4 Unknown Records, 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has to page 2 s performe 1 Yes 2 No this certificate Division of Vital funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 2 🗌 No မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: hin 24 hours after death.

the Funeral Director: After

mpleted filled in by the funer injury 1 Natural 5 Pending Accident 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated. (Check within 2 3 L only one) 29b. Signature and title of who completed cause of death (Item 23a) (Type, Print) d Ó

State

Registrar

. Date filed (Month, Day,

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month Year Day ohnsor 6:27 p M Medical 2011 4a. Facility Name of not institution, give street and number)
Levindale Geriatric C **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Center NA Baltimore 5. Social Security Number 8. Date of Birth
(Month, Day, Year)
Feb 2, 1940 If Under 1 Year I If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs, last birthday, 1 ★ M 2 □ F Days Months **Director** 213-36-0334 MD Usual Residence of Decedent 28a-f shov 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director Baltimore MD NA 1X Yes 2 ☐ No ъ 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 21207 23 Summerfield Road USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Examiner Armed Forces' Black, White, etc. ō Completed by 1 Never Married 2XXMarried 1 X Yes 2 No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black 3 Divorced Year or Dates traumatic event, the Medical 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) National Security Agny Yrs. Communicator 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Josephine Brown Charles Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 23 Summerfield Rd. Balto., MD 21207 Theresa Johnson - Wife Health a Department of Health Important: If item 27 any injury or other tr Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 🕅 Cremation 3 ☐ Removal from State 4 🖟 Donation 5 ☐ Other (Specify) cemetery, crematory or other place) On- Site Cre. Ecnter 02/07/11 Baltimore, MD 21. Signatu of Funeral Service License 22. Name and Address of Facility 4300 Wabash Ave. Balto., MD 21215 March Funeral Home West, Inc. Par. 1. Enter the trisease, or complications that rused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shick, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immedi te Cause (Fin Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Securitielly list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury onges burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 phy 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Year P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autonsy death? 1 ☐ Yes 2 ☐ No Yes 2 40 Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital 1 Tyes 2 4 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Division of 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Hospital or Attending injury Natural 5 Pending after death.

Director Aff
in by the fur Accident
Suicide 1 Yes 2 No. Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined completed filled Medical 29a. Certifier Lecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Signature and person who completed cause of death (Item 23a) (Type, Print) address O al Date filed (Month, Day, 08 2011

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle. Time of Death Day eula Physician 2011 +50 A M 26 0 2 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Charles vilure Care Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 08 25 Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Hours Months Days 1 □ M 2√□ F Director 95 NC 215-05-9465 Usuel Residence of Decedent tha Maryland 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County r 28a-f ehow 1X Yes 2 No Director NA Baltimore MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code or Items 23a or 2 cultier must be n daath with 21223 U.S.A. Saratoga Street 2210 West Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: filed within 72 hours atte 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ö 1 ☐ Yes 2 No Specify: Specify: Completed by Black 3 XWidowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry rthen Itse College (1-4or 5+) Elementary/Secondary (0-12) Self Employed 12th grade 2yrs <u>Beautician</u> othert 17 is marked other trsumatic event, 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 9 P Edgar Powell Sadie Bailey

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) tem 27 other tra 2624 Cecil Ave, Baltimore, Md 21218 Mr. Isa Shah-Nephew 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Dapartmant of H
Importent: If Ite
ony injury or of 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Ponation 5 ☐ Other (Specify) Maryland National 2/9/2011 Laurel, Md 21. Sig latur 22. Name and Address of Facility
March F/H West of Funeral Service Licensee 4300 Wabash Ave, Baltimore, Md 21215 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each Lie. Approximate Interval Between Onset and Death Cardis V & Sa Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physician and the burial-transit or Attending Physicien: The law raquiras that the death cartificate be executed Due to (or as a consequence of): P.O. Box 68760. Physician/Medical attanding p for usa as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 mon Month Day 4□Pregnant at time of death 5 Other (specify) been signed by tha should be datached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, \$ 1 Yes 2 No 3 Probably 4 Hiknown Completed 24b. Were autopsy lindings available prior to completion of cause of death?

1 \( \text{Yes} \) 24a. Was an cartificata has biractor, paga 2 s 1 Yes diractor 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Aursing Home 5 Residence 6 Other (Specify) 2 1 Tes 2 16 this Aftar thi funaral 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) Medical Certification: 27. Manner of Death Natural 28b. Time of 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No daath. Director: / 2 Accident investigation 6 Could not be determined 3 Suicide 28l. Location (Street and Number or Rural Route Number. City or Town, State) 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours a
To the Funeral I
completaly filled 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and marmer stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Registrar

31. Date filed (Month, Day, Year)

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32. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2011 03:45 ам Jones. Sr. Edward Charles Medical 4b. City, Town, or Location of Death 4a, Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** Baltimore Baltimore 2604 Cub Hill Road If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 🛛 M 2 🗆 F Months Days Hours 06/22/1924 219-10-3907 86 MD **Director** Usual Residence of Decedent items 23a or 28a-f show her must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director 1 Yes 2 X No Baltimore Baltimore 10f. Zip Code 10e Street and Number 10g, Citizen of What Country? Funeral 21234 U.S.A. 2604 Cub Hill Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 12 Was Decedent Ever in U.S. 11. Marital Status Jral", or iter Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 🔀 No Specify: If Yes, Give Year or Dates. "natural", Completed 3 Widowed 4 Divorced event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Meat Business Credit Manager 12 permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, the Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ္ S. McKenny Almira Jones Charles 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2604 Cub Hill Road, Baltimore, MD 21234 Norma J. Jones, Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Durial 2 Cremation 3 Removal from State 02/07/2011 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Svc. Corporation 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Leonard J. Ruck, Inc. 5305 Harford Road, Baltimore, MD 21214 Mesondua of Eslav 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ARKINSON PANG disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed and the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day Year Pregnant at time of death 2 No page 2 should be detached 9 Unknown Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed? 1 Yes 2 No completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) Other (Specify) 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending work? To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A 1 🗌 Yes 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Securifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

11-00910 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

JNK UNK		State of Maryland / Department of  1-For State  Certificate of			001	1 1000
Physic	an/	Registrar  1. Decedent's Name (First, Middle,Last)	Dodan	2. Date of Deat		3. Time of Death
Medical Exam		Melvin Francis Johnson		Month February 2	Day Year 2, 2011	0755 hrs
		4a. Facility Name (if not institution, give street and number)  4	b. City, Town, or Location of Dea	ath	4c. County of De	eath
		4200 Block of Harford Road	Baltimore	. lo p		D. C. C. C. C. C. C. C. C. C. C. C. C. C.
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24H Months Days Hours M	Ain	th(MM/DD/YYYY) 9.	reign
		213-32-4098 1 M 2 F 74 Yrs.		06-19	-1936	Country)
à		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location	on			10d. Inside City Limits
d how s	_	MD Baltimor	CO			1 Yes 2 No
ayla (1)	Director	10e. Street and Number	10f. Zip Code	10	Og. Citizen of What C	ountry?
the M	ā	3604 White Ave.	21206		115	
hours after death with the Maryland 'natural', or items 23a or 28a-f ah Examiner must be notified at once	uneral		Decedent of Hispanic Origin? (			nerican Indian, Black,
death or ite	Fun	1 Yes 2 No	es, specify Cuban, Mexican, Puer	no Rican, etc.)	White, etc	21 - 10
ral",	þ	or Dates:	Yes 2 No specify:		Specify:	TACK
hour hour Exam	ted		's Usual Occupation (Give kind o est of working life. DO NOT use r		16b. Kind of Busine	ss/Industry
0036 within 72 piene.	ple		sabled		Disabil	ad
5-0036 led within 72 hou Hygiene. other than "nai	Completed	17. Father's Name (First, Middle, Last)		me (First, Middle, M		eo
	Be (	Earl Johnson	Unk	nown		
2 4 5	ဥ	19a. Informant's Name/Relationship (Type, Print )	Address (Street and Number o	or Rural Route Num		ate, Zip Code)
9, MD and 2 sho fealth and ftem 27 is			Winchester St			216
TOFE, ages l ar of Hez		20å. Method of Disposition  20b. Place of Disposition  1 Furial 2 Cremation 3 Removal from State crematory or other		Date	20c. Location - City	or Town, State
Page Page ment tant:		4 Donation 5 Other Specify: M Zion	Cemetery 2	-7-2011	Baltimo	re, MA
Baltimore permit. Pages 1: Department of H. Important: If it injury or other t		21. Signature of Juneral Service like (954) 22. Na	ame and Address of Facility	MASON F	warne	Service
		23a Part Fifter the disease or complications that caused the death. Do not enter the	Kennedy S+ N	washi	ng/on D(	Approximate Interval
Physician /Medical		23a. Part f. Enter the disease, or complications that caused the death. Do not enter the failure. List only one dause on each line. Alzheimer's Demen	ntia and Parkin	son's Di	sease	Between Onset and Death
Examiner		Immediate Cayse (Final disease or condition resulting in death)  a. Complicated by Hy Due to (or es e consequence of):	ypothermia			20001
		Sequentially list conditions, b				
	ner	ff any, leading to immediate Due to (or as a consequence or).  cause. Enter Underlying Cause			<del>-</del> .	
0 - 4	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
and and - transi		d				
e ex ician	dical	■ UNPENDED	per me g913 3-3	80-11 vt		
Box 68760, e death certificate but attending physical for use as the but of for use as the but of t	울	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of deliv	
certif	cian	past 12 months?	al death 3 Ectopic preg	nancy	Month	Day Year
	ıysi	1 Yes 2 No 9 Unknown 9 Unknown	er (Specify)			
	/ Phy	Pert II. Other significant conditions contributing to death but not resulting in the unit	derlying cause given in Part I.	23e. Did tot	pacco use contribute	to the cause of death?
Records, P.O. The law requires that th cate has been signed by page 2 should be detach	d by			1 Yes	2 No 3 P	robably 4 🗹 Unknown
ords, w requires to been a should	ete			24a. Was a autops		autopsy findings available o completion of cause of
eco he law ite has	Completed			perform	med? death	?
in the state of	Ф	25. Was case referred to medical	26.Place of Death (Chec			
ion of Vita trending Physicia leath. tor: After this ce	8	examiner?  1  Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient	3 DOA Other Nurs	sing Home 5 T	Residence 6 🗸 Ot	her: Scene
n of ding Ph After ti funeral		27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury			ow injury occurred	and to the
Sion Attendi r death. ector:	랿	Natural 5 Pending Pending Investigation Fd 2-2-11 Fd 7:40a	ann 1 Yes 2 X No	cold	,	sed to the
Divising pital or At ours after defend Direct filled in by	Certification:	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street,	, factory, office building, etc.	28f. Location (Story Town, Story treet and Number or ate) 4200 b	Rural Route Number, City ock of Harfo	
Div Hospital or 24 hours afte Funeral Diu	3	4 Homicide determined (Specify) in a park		Rd. Bal	to. City,	Md.
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Sa	29a. Certifier (Check only one)  2 Medical Examiner: On the basis of examination and/or investigation				
To the within To the complete	Medical	and manner stated.  29b. Signature and title of certifier	29c. License number	1	29d. Date signed (i	
			O.C.M.E.		February 2, 20	
		30. Name and address of person who completed cause of death (Item 23a)				
ok perd		V	timore Street, Baltimore,	MD 21223		
	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature				
Regist		FEB 0 8 2011				
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DHMH 17 Rev 1/2001 OCME 2006

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ February 6, 2011 Veronica C. Jackson 3:45 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Gilchrist Center Towson Baltimore Social Security Number 217-24-9696 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth Funeral 1 □ M 2 🗓 F Months (Month, Day, You 19. 81 Marviand Director Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a, State death with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director N/A MD Baltimore 1 X Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7722 Bagley Avenue 21234 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or in any injury or other traumatic event, the Market. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. If Yes, Give Year or Dates Specify: White Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Social Security Elementary/Seconday (0-12) Technician Accounting 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 William H. Tully Sarah M. Ouillen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Patricia Stewart/Daughter 7722 Bagley Avenue, Baltimore, MD 21234 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State February Evans rematery or other place) Chapel - Bel Air 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State  $07, 201\bar{1}$ Forest Hill, MD 4 Donation 5 Other (Specify) ature of Funeral Service Licensee Name and Address of Facility Vans Funeral 800 Harford Eyans 8800 Chapel & Cremation Services 13a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest nock, or heart failure. List only one cause on each line. Onset and Death ediate Cause (Final Physician/ is ase or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Division of Vital Records, P.O. Box 68760 the attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? for Month Dav Year Pregnant at time of death 5 Other (specify) 2 LINO cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 1 After this certificate has 1 ☐ Yes 2 ☐ No funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes 2 No Hospital Other: ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28b. Time of 28a. Date of injury Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending injury s after death. 1 ☐ Yes 2 ☐ No Accident Investigation the Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number. filled in by determined 24 hours Medical 29a, Certifier ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I only one) 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and itle of cer 29c. License number 29d. Date signed (Month, Day, Year) D71040 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N CHARLE RALTIMORE 701 ARAT HI

DHMH 17 Rev 7/2009

State

Registrar

. Date filed (Month, Day, Year,

FEB 0 8 2011

arked

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ February 2011 5:30 АМ Arleen Mae Jones Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore 12 Saint Elmo Ct. Apt. X1 Cockeysville 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 □ M 2 🕱 F Days May 17, Year) 929 229-32-3046 Director 81 Lynchourg, Virginia Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director Baltimore Cockeysville Maryland 1 Yes 2 XXIo 10e. Street and Number 10f. Zip Code onited States Funeral 21030 12 Saint Elmo Court Apt. X1 of America 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc þ 1 Never Married 2 Married Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours afte Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: white Specify: Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Murray Elementary/Seconday (0-12) College (1-4 or 5+) Accounting Clerk Corporation 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Rosa Compton James Washington Davis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
12 Evans Avenue Timonium, Maryland 21093 Carol A. Sullivan/daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of H Friday, 20c. Location - City or lown, State
Feb. 04, 2011, Forest Hill, Maryland Evans Funeral Chapel – Bel Air 1 🗆 Burial 2 🙀 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Jeffrey L. Gair, Sr. 22. Name and Address of Faculty Peaceful Alternatives Funeral and Cremation Center, P.A. Jan, L. Lic. #100677 2325 York Road Timonium, Maryland 21093 1. Enter the disease, v complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ INFARCTION VOCARDIM disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregrant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ CANCER, RHEUMATOID ARTHRITIS Records, 2 🗹 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed Yes 2 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Mann of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 🖳 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check FEBRUMY 3, 2011

ク<sup>v</sup>

DHMH 17 Rev 7/2009

Registrar

32. Registrar's Signature

1 TEXAS STATION COURT #210 TIMONIUM, MARYLAND 21093

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CARR, MD

31. Date filed (Month, Day, Year)

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		Please Type or Print in B						
	•	1 - State of Maryland Registrar	•	tificate of D			g. No. 2011	03310
Physiciar Medica		1. Decedent's Name <i>(First, Middle, Last)</i> Maria Kazaras				2. Date of Death Feb.	Day 2011	3. Time of Death 3:00 A M
Examine		4a. Facility Name (if not institution, give street and number)  Heritage Center			Location of Death		4c. County of Death	
Funeral Director		5. Social Security Number 217-24-7690 C. Sex 1 □ M 2 ▼ F 101	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Dec. 13	9. Birth (ear) 1909 As 14	nplace (State or Foreign Herry) Minor
Maryland 28a-f show notified at	Director	MD Baltimore	Town or Lo	Dundalk	ξ			10d. Inside City Limits 1 ☐ Yes 2 🏹 No
with the 23a or ust be r	Funeral D	10e. Street and Number 7232 German Hill Road		10f. Zip Code	21222		lg. Citizen of What Cou <b>Jnited Sta</b> t	
ter o	۾	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 🏋 Widowed 4 ☐ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates.	1	Vas Decedent of His Yes, specify Cubar	spanic Origin? (Spe n, Mexican, Puerto Specify:	cify Yes or No- Rican, etc.)	14. Race - Ameri Black, White Specify: W	
within 72 hour giene. er than "natu , the Medical	Completed	(Specify only highest grade completed)  Elementary/Seconday (0-12)  College (1-4 or 5+)	(Give I life. D	ent's Usual Occupa kind of work done d D NOT use retired) <b>ESSWOMAN</b>	ation uring most of worki	ng	6b. Kind of Business II Restaurant	ndustry
d be filed Mental Hyg arked oth ritic event,	To Be	17. Father's Name (First, Middle, Last) Alexander Moraitis			18. Mother's Name Krystalla			
id 2 should saith and N n 27 is ma		· · · 66/- ·					ity or Town, State, Zip Maryland	
t. Page 1 an tment of He tant: If iten ijury or oth		1   Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	netery, cren k Ort	sition (Name of natory or other place hodox Cen	n. 02/0	9/2011   1	Oc. Location - City or 1	Maryland
Depar Impol any ir		21. Signature of Funeral Service Licensee Alyson K Tayl	or   22 3	. Name and Addres 01 Freder	s of Facility Mar cick Rd.,	cNabb Fui Catonsv	neral Home ille, Mary	, P.A. Land 21228
i i i i i	al Examiner	23a. Part 1. Enter the disease, or complications that caused the death. I shock, or heart failure. List only ne cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence or consequence).  Due to (or as a consequence).	LE k nce of): T/A nce of):	r the mode of dying	g, such as cardiac of	r respiratory arrest	NAR :	Approximate Interval Between 2 Onset and Death A
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the bu	Physician/Medical	d	eath 3	Ectopic pregnance	У		23d. Date of deli Month	very Day Year
equires that the sen signed by ould be detac	^	Part II. Other significant conditions contributing to death but not result	ing in the u	nderlying cause giv	en in Part I.	23e. Did toba	cco use contribute to	the cause of death?
icate has be	Completed					24a. Was an autopsy perform	prior to c death?	opsy findings available ompletion of cause of 2  No
nysiciar nis certif directo	To Be	25. Was case referred to predical examiner?  1  Yes 2 No	₹/Outpatien	Othe	ace of Death Checker: 4 Nursing Ho		ce 6 Other (Special	fy)
Attending Plander Plander Plander III by the funeral	Certificate:	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	Bb. Time of injury e, farm, stre		? Yes 2 \( \subseteq No		et and Number or Run	al Route Number,
ospital or hours afte ineral Direct of filled in	Medical Ce	29a. Certifler 1 Certifying Physician: To the best of my knowled					e(s) and manner as stat	
To the H within 24 To the Fi complete	Me	(Check only one) 2 Medical Examiner: On the basis of examination a only one) 3 Certifying Nurse Practioner: To the best of my kings. Signature and tale of certifier			time, date and plac	e, and due to the c		stated.
21		30 Name and address of person wito opppolyted cause of deposition in	M	A69-A	RIJC	HIE H	15HWA	4,
State Registra	7	31. Date filed (Month, Day, Year) 32. Registrar's Signature	4	·		·		
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death February 3. Physician/ Robert James Kelly 2011 7:20 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Gilchrist Hospice Care Towson If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 □ F Months Days Hours Min (Month, Day, Year) an. 5, 1967 New York 43 Jan. **Director** 126-42-6096 Usual Residence of Decedent or 28a-f show notified at 10b. County 10d. Inside City Limits 10a. State 10c. City. Town or Location death with the Maryland Director 1 Yes 2X No Baltimore MD Baltimore 10g. Citizen of What Country? 10f. Zip Code 5 10e. Street and Number must be n Funeral 5933 Harford Avenue 21207 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian. 11. Marital Status Examiner Armed Forces? Black, White, etc. 0 þ 1 Never Married 2 Married White Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 🖾 No Specify: If Yes, Give Year or Dates "natural", Completed 3 Widowed 4 Divorced the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Air & Space Factory Worker ge 1 and 2 should be filed with tof Health and Mental Hygien If item 27 is marked other to or other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Catherine Whelan Jeremiah James Kelly 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1717 Worthington Heights Parkway; Cockeysville, M21010 Kathleen Kelly Sister Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Atlantic Crematory 20c. Location - City or Town, State 20a. Method of Disposition Date <u>=</u> 6 1 Burial 2 X Cremation 3 Removal from State Department of Important: If any injury or 2/7/2011 Glen Burnie, MD Donation 5 Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 ign lure of Funeral Service Liouns Part 1. Enter the disease, of complications that caused the death. To not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ PHAGEAL PAR disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events attending physician and for use as the burial-tran To the Hospital or Attending Physician: The law requires that the death certificate be execu Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Year Month Dav Pregnant at time of death Unknown 2 No. pege 2 should be detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by CONGOSTIVE HEART FAILURE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown een 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an performe After this certificate Yes within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, t 25. Was case referred to fiedical 26. Place of Death (Check only one) Be examiner? 24 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Spe 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 1 Natural 2 Accident 5 Pending work 1 Yes 2  $\square$  No Investigation 6 Could not be 3 
Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

FEB 0 8 2011

e and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM# 2perPHYS, G912, 2/15/2011, WS

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2, Date of Death Month**Feb** • 2011 3. Time of Death 1 Decedent's Name (First Middle, Last) Day 5 **Physician** 9:00 A M Helen B. King Feb. -3 2011 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Holly Hill Nursing Home Baltimore Towson If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Months Days Hours 1 □ M 2√2 F Yrs. 90 28 1920 MĎ Director 214-12-2333 Oct. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County d other than "natural", or items 23a or 28a-f show event, the Modical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director MD Baltimore Sparks 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21152 USA 619 Cold Bottom Road Funeral death 12. Was Decedent Ever in U.S Armed Forces? 1 ☐Yes ②☐No If Yes, Give Ye ar or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: WHITE þ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Baltimore County Elementary/Secondary (0-12) College (1-4or 5+) Soil Conservation 12 n/a Bookkeeper 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Health and Mental George Lawrence Buckingham ပ Caroline Elizabeth Schenkel 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If Item 27 any injury or other troone. Carolyn King Shorts/daughter 619 Cold Bottom Rd., Sparks, MD 21152 Saltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Vernon United 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12/8/11 White Hall, MD Methodist Cemetery 21. Signature of Funcial Service Licenses 22. Name and Address of Facility Michael J Lemmon Funeral Home of Dulaney Valley, Inc. 10 W. Padonia Rd., Timonium, MD 21093 Flagle 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final years **Physician** disease or condition resulting in death) /Medical Due to (or as a nsequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Disa to for esta consequence offi attending physician and for use as the buriat-transi Due to (or as a consequence of) P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 🔲 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown cate has been si page 2 should b 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director, pag 1 ☐Yes 2 ☑No 1 🗆 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 7.

State Registrar

16

7402 York Rd., Suite 301, Towson, MD 21204

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

Dr. Theodore C. Houk

FEB 0 8 201

31. Date filed (Month, Day, Year,

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene

Michael Knauer		- For State Registrar	St	tate o	f Marylan		-	ent of ate of		na Men	tai Hygi		g. No.	2011	03313
Physician Medical Examine	1	Decedent's Name	e (First, Midd	le,Last)	Michael	B <b>lan</b> e	Knaue	er				Date of Death Month ebruary 2	h	Year	3. Time of Death 2035 hrs
TOUISE EXCHANGE		4a. Facility Name (i		-	treet and numb	per)		41	o. City, Town, o			ebidary_2	4c. (	County of Deat	
Funeral	4	9107 Moons 5. Social Security N		d 6. Sex	7.	Age (In	yrs. last bir	rthday)	Nottinghan		r 24Hrs.   8.	Date of Birt		Iltimore Co	rthplace (State or
Director		217-56-980	)3		2 F	57		Yrs.	Months Da	ys Hours	Min. (	Oct 6,	1953	Forei Co	gn ountry) MD
any	_	Usual Residence of 10a. State	10b. County			10c.	City, Town	or Location					-		10d. Inside City Limits
Aaryland 28a-f show Latonce	<u> </u>	MD 10e. Street and Nu	Balti	more				Notti	ngham 10f. Zip Code		*	I10	n Citize	en of What Cou	1 Yes 2 No
n the Maryland 3a or 28a-f sh otified at onc		9107 Moon		Road						21236				U.S.A.	
or death with the Maryland , or items 23s or 28s-f sho craust be notified at once. Finneral Director		11. Marital Status  1 Never Marrie	ed 2 M		2. Was Deced Armed Ford Yes				Decedent of H s, specify Cuba				1	4. Race - Ame White, etc.	rican Indian, Black,
ral", o		3 XWidowed  15. Decedent's Ed			Yes, Give Year r Dates:			1	Yes 2XX N		kind of work	done		pecify: What of Business	iite //ndustry
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within siene.	-	12 17. Father's Name	/Eiret Middle	Last)	6+		Cc	omputer	Program			st, Middle, N		Rowe Pr	nce
21215-0036 uld be filed within 7 Mental Hygiene. marked other than ic event, the Medica		William H.	•									Zelinco			
MD 21 d 2 should 1 lth and Mee n 27 is man umatic ev	2	19a. Informant's Na Matthew Kna			e, Print )		19		Address (Stre loon Ston					or Town, State 21236	e, Zip Code)
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Physician		23a. Part I. Enter th		on each	line.			ot enter the	e mode of dying	g, such as c	ardiac or res	spiratory arre	est, shoc	k, or heart	Approximate Interval Between Onset and Death
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Vital F hysician: this certifi director,		examiner?	2 No		spital: 1 Inp	atient :	2 🔲 ER/C	Outpatient	(=)	Other	Nursing H	ome 5		ce 6 🗸 Othe	er: Scene
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Division of Vital Records, P.O. spital or Attending Physician: The law requires that t tours after death.  neral Director: After this certificate has been signed by filled in by the funeral director, page 2 should be detac		2 Accident 3 Suicide	Inve	estigation ald not be ermined		of Injury -	At home, f	farm, street	, factory, office	building, et	c. 28f	Location (S or Town, S		d Number or R	tural Route Number, City
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 02 01 2011 11:15A<sup>M</sup> Kenneth Kerns Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 405 Winton Avenue Glen Burnie Anne Arundel 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** Days 1 XM 2 □ F Months Hours Min. Director 236-56-3376 80 Yrs 0/04/1930 Usual Residence of Decedent 10b County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director "natural", or items 23a or 28a-f s edical Examiner must be notified 1 Yes 2 X No MD Anne Arundel Glen Burnie 10e. Street and Number 10g, Citizen of What Country? Funeral 405 Winton Avenue U.S.A. 21061 filed within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces?
1 X Yes 2 □ No Black, White, etc. þ 1 Never Married 2 Married 1 X Yes 2 Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 3 XWidowed 4 Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry al Hygiene. Social Security Elementary/Seconday (0-12) College (1-4 or 5+) Disability Examiner Administration Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental is marked ပ္ should be traumatic 0ra Raymond Kerns Virginia Α. Bailev 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Teresa Godfrey / Daughter 9542 North Saxifrage Way Citrus Springs, FL 34433 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Important: If it any injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Veterans Cemetery 02/07/2011 MD4 Donation 5 Other (Specify) Crownsville, MD Signature of Funeral Service 22. Name and Address of Facility 2nd Avenue SW Glen Burnie, MD Singleton Funeral & Cremation Services, PA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Physician/ arano ma Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): attending physician and for use as the burial-transit death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Pregnant at time of death 2 No the g Unknown g Linknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by þe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 K Unknown Records, 24b. Were autopsy findings available 24a. Was an The law autopsy performed? prior to completion of cause of death? page 2 2 🗌 No 2 X No 1 Yes within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, I 25. Was case referred to medical of Vital Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Schesidence 6 Other (Specify) 1 Yes 2 1 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Hospital or Attending Natural Accident Suicide 5 Pending Division 1 Tes 2 No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the 1 only one) 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) D38958 Crain Heghway Sw Glin Burnie MD21061 address of person who completed cause of death (Item 23a) (Type, Print) Name and (Month, Day, Year, 32. Registrar's Signature State 08 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Kotowski James 201 02 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Himo Liline Hmare If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Funeral 1 ☒ M 2 ☐ F Hours Min. April 21 Year 1923 Maryland 217-14-3964 87 Yrs Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: I fiem 27 is anarked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🛂 No Baltimore Edgemere 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21219 United States Apt. 225 2829 Lodge Farm Road 12. Was Decedent Ever in U.S. Armed Forces?

1 ☒ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White Year or Dates. WWII 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12 Years College (1-4 or 5+) Steel Industry Supervisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Anna Sarnecki Andrew Kotowski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip 8034 Midhaven Road Dundalk, Maryland Elaine Gerke (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other (Specify) Towson, Maryland Hilltop Service Corp. 2/9/2011 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 21. Signature of Funeral Service Licenses Part 1. Enter the disease complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure, so only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or imjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): igned by the attending physician be detached for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year Pregnant at time of death 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy performed? Yes 2 N After this certificate 1 ☐ Yes 2 ☐ No completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother (Specify) assisted live 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending after death. 1 Tes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Exertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 10x1 Name and address of person who completed cause of death (Item 23a) (Type, Print) 40 Eusten Holder 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ FEBRUARY 2011 8:55 PM KAHN JOHANNA Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** HOWARD COLUMBIA 5242 HERMIT PATH 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 1 🗆 M 2 🗓 F 0372671912 **GERMANY** 98 219-16-4260 **Director** Usual Residence of Decedent show 10d Inside City Limits 10c. City, Town or Location 10a. State 10b. County with the Maryland "natural", or items 23a or 28a-f sho Director 1 Yes 2 X No COLUMBIA HOWARD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 21044 USA 5242 HERMIT PATH Page 1 and 2 should be filed within 72 hours after death 1 ment of Health and Mental Hygiene.

tant: If item 27 is marked other than "natural", or items lury or other traumatic event, the Medical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces?

1 Yes 2 No Black White, etc. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: WHITE 3 X Widowed 4 Divorced Year or Dates. 16a, Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) TAILORING SEAMSTRESS 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ SAMUEL SAMUEL REGINA ABRAHAM 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5242 HERMIT PATH, COLUMBIA, MD CAROL LEWIS/DAUGHTER Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c Location - City or Town, State 20a. Method of Disposition permit. Page 1 a
Department of H
Important: If ite
any injury or ott XBurial 2 Cremation 3 Removal from State CHEVRA AHAVAS CHESED 02/06/2011 RANDALLSTOWN, MD 4 Donation 5 Other (Specify) Funeral Service ons 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Sig, 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) CO26 ESTIUS Medical Due to (or as a consequence of): Examiner REIDIRATERY Sequentially list conditions. Examine Due to (or as a consequence of) it any, leading to immediate cause. Enter Underlying Cause (Disease or linjury ARRYTAMIA Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transil that initiated events Due to (or as a consequence of) resulting in death) Last the attending physician Physician/Medical P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No for Month Day Year Pregnant at time of death 5 Other (specify) signed by the a d be detached fo 1 Yes 2 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>6</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4. ☐ Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has performed' 1 ☐ Yes 2 ☐ No. this certificate 2 - N 25. Was case referred to medical examiner? **Division of Vital** funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Tes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 28a. Date of injury (Month, Day, Year) 28c. Injury at 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: After work? 1 ☐ Yes 2 ☐ No 5 🗌 Pending 1 Natural ☐ Accident Investigation hours after death npleted filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 24 hours a Funeral I Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title

State Registrar

31. Date filed (Month, Day, Year) FEB 0 8 2011 DHMH 17 Rev 7/2009

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GIAMIEN

32. Registrar's Signature

30. Name and a viress of perion who completed cause of death (Item 23a) (Type, Print)

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68760 Box ( Records, Division of Vital Hospital or Attending 24 hours after death. Funeral Director: A completed within 2 To the F

State Registrar DHMH 17 Rev 7/2009 only one)

29b. Signature and title of certifier

Browner 31. Date filed (Month, Day, Year)

FFR 0.8 2011

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Browner, MD

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32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4940

29c, License number

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les i-uary

21224

2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death 6 Day Edwin Physician/ Webster Lard Feb min 2011 6:50 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sunrise Assisted Living Columbia Howard If Under 1 Year | If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign 5. Social Security Number 6. Sex 1 X M 2 □ F 7. Age (In yrs. last birthday) **Funeral** July 17 Months Days Min. Alabama 89 Director 429-28-1300 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at Director Columbia 1 🗌 Yes 2 💢 No MD Howard 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ò Funeral items 23a 6500 Freetown Road, Room 233 21044 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. WW II Black, White, etc. 5 þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White "natural" Completed 3 Widowed 4 Divorced traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. other than " College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Chemical Engineer Research & Developement Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental h ည Robert Alice Webb Lard Mamie permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic v John 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6500 Freetown Road, Room 233 Columbia, MD Virginia H. Lard, wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 🂢 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 02/07/11 Baltimore, MD Signature of Funeral Service Licensee George MacNabb 22. Name and Address of Facility Cremation Society of MD, Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Examir requires that the death certificate be executed Due to (or as a consequence of): physician a s the burial-Physician/Medical Box 68760 attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23h. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No ed by the a detached f 1 Yes 2 L 9 Unknown g Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 3 Probably 4 Unknown plnods Completed 24b. Were autopsy findings available 24a. Was an autopsy performed? Yes 2 prior to completion of cause of death? 1 Yes 2 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be 4 Nursing Home 5 Residence 6 Assisted Living examiner? 2 No Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this of completed filled in by the funeral director. 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 Yes 2 🗌 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiper On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse gractioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) DY744 un D February 7, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10V 1921 334 (ary State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - State of Maryland / Department of Health and Mental Hygiene State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year 2011 Month Physician/ : 55 A M LAZARUS FRANCES Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner OSPITAL BAUTIMONE If Under 1 Year If Under 24 Hrs Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 □ M 2**X** F 10/20/1921 Months Days Hours MD Director 89 216-14-3595 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location with the Maryland Director 1 X Yes 2 No MD N/A BALTIMORE 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number items 23a or ner must be n Funeral 3211 CLARKS LANE, #211 21209 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14 Bace - American Indian 11. Marital Status "natural", or iter dical Examiner Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: If Yes, Give Year or Dates WHITE Completed 3 ☐ Widowed 4 ☐ Divorced the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 12College (1-4 or 5+) and Mental Hygiene. is marked other tha GROCERY STORE CASHIER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental Important: If item 27 is marked o any injury or other traumatic eve and. မ VIRGINIA BIAGIA FRANK **FAVAZZA** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22ND STREET, #6E, NEW YORK, NY DIANE LAZARUS/DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State OHEB SHALOM MEM. PK.: 01/24/2011 REISTERSTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., 21. Signature of Puneral Service Licencee 21208 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on profit line. Approximate Interval Between Onse and Deat Immediate Cause (Final nemori Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner Due to for as a consequence of, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events or Attending Physician; The law requires that the death certificate be executed the burial-transi and Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 SS IF FEMALE: detached for use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant/ 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months Month Year Dav 4 Pregnant at time of death 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be DEHYDRATION 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown ALUTE RENAL FAILURS 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy LIVER INJURY performed' certificate 1 ☐ Yes 2 ☑ No Yes 2 🛶 25. Was case referred to medical completed filled in by the funeral director, 26. Place of Death (Check only one) Be Hospital: 1 X Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mann f Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at 28d. Describe how injury occurred Certificate: ✓ Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation safter death 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) JANUARLY 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOSPITAL OF MUTIMORY AVITE 31. Date filed (Month, Day, Year) 2. Registrar's Signature State FEB 0 4 2011 Registrar

DHMH 17 Rev 7/2009

AZARUS

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death Decedent's Name (First, Middle, Last) 2. Date of Death Sincian Physician/ 04/M Claude Harvey Leer Medical Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c County of Death **Examiner** IVISTA harles Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Age (In vrs. last birthday) **Funeral** Min. 1 🛛 M 2 🗆 F Months Days Hours Feb. 6, 1920 Washington, DC 579-05-0085 90 Director Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10b. County 10d. Inside City Limits 10c. City, Town or Location Director 1 X Yes 2 No Maryland White Plains Charles 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 4210 Southwinds Place 20695 U.S.A. Apt. within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces? 1943 1  $\boxed{3}$  Yes  $2 \square$  No If Yes, Give 1945Black, White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. Specify: White 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Air Conditioning Installation & Service Elementary/Seconday (0-12) College (1-4 or 5+) Conditioning Mechanic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Frank A. Leer Marie Harvey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Nora Estelle Leer Southwinds P1. Apt. 213 White Plains, MD 20695 (Wife) 4210 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 

Burial 2 

Cremation 3 

Removal from State Metropolitan Crematory 2/7/2011 4 Donation 5 Other (Specify Alexandria, VA 22. Name and Address of Facility Rose Mortuary 66424 Pierson B 21. Signature of uneral Service Licen: Blvd.. Desert Hot Springs men 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to be as a consequence of 20 Vascula Hospital or Attending Physician; The law requires that the death certificate be executed anding physician and use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last there sclenotice Physician/Medical Division of Vital Records, P.O. Box 68760 attending IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Pregnant at time of death g 🗌 Unknown the 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an is certificate has director, page 2 s autopsy performed 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?

1 Yes 2 No Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) ၉ 1 KInpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending work? 2 🗌 No Accident Suicide Investigation Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a To the Funeral I Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 1246419 ne and address of person who completed cause of death (Itom 23a) (Type, Print) Charlene Anne Letchford DJ 31. Date filed (Month, Day, Year) State FEB 08 Registrar

DHMH 17 Rev 7/2009

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Due to (or as a consequence of):  Atheroscierostic Conditions of the supplied			Immediate Cause (Final disease or condition					Approximate Interval Between Onset and Death
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29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Signature and title of certifier  29b. Signature and title of certifier  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  31. Tonya Mason, MD 900 S Caton Ave, Baltimore, MD 212249	S 5 5	<b>∞</b> ∣	examiner?	1 ☐ Inpatient 2 ☐ ER/Out	Othor			ify)
29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier  29c. License number  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  K. Tonya Mason, MD 900 S Caton Ave, Baltimare, MD 212299	ending Ph sath. or: Af er th he fur eral	ation:	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	Date of Injury 28b. Ti (Month, Day, Year) In	jury Work?		how injury occurred	
29a. Certifier (Check only one)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier  29c. License number  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  K. Tonya Mason, MD 900 S Caton Ave, Baltimare, and due to the cause(s) and manner as stated.  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  40c. Tonya Mason, MD 900 S Caton Ave, Baltimare, MD 2003-29	tal or Attu	Certific	3 ☐ Suicide 6 ☐ Could not be determined 28e. F	Place of Injury - At home, fari building, etc. <i>(Specify)</i>	m, street, factory, office			ral Route Number,
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  K. Tonya Mason, MD 900 S Caton Ave, Baltimore, MD 27229	Hospi		(Check only 2 Medical Examiner: On	the basis of examination and	death occurred at the time, d l/or investigation, in my opinio	late and place, and due to the n, death occurred at the time	e cause(s) and manner as , date and place, and due	stated. to the cause(s)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  K. Tonya Mason, MD 900 S Caton Ave, Baltimore, MD 21229  31. Date filed (Month Day Year)  32. Represents Simply year	To the Community of the	Ž	29b. Signature and title of certifier					
31 Data filed (Month Day Year) 32 Registrar's Singstrue	6			cause of death (Item 23a) (1	Type, Print)	Raltin =	tebruar	y 3,201
Spice of bato med (mortal, bay, real)	State	e		32. Registrar's Signature	COTON HVE	Daltimo	N.C. MIJd	1207

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ Mont 2 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) Town, or Location of Death **Examiner** Q 8. Date of Birth 9. Birthplace (State or Foreign Age (In yrs. last birthday) If Under 24 Hrs. **Funeral** Months Days Hours Min. 1 XM 2 □ Y Director avolino Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits be notified at Director 1 Yes 2 No 10g. Citizen of What Country? ь 10e. Street and Number 10f. Zip Code 23a Funeral permit. Page 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23 any injury or other traumatic event, the Medical Examiner must I 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify Widowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life: BO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ 2in 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place Donation 5 🗆 Other (Specify) 21. Signature of Auneral Se vice Lje∕ensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ concer disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of): Due to (or as a consequence of): resulting in death) Last burial attending physiciar Physician/Medical law requires that the death certificate be 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown use 23d. Date of delivery 23b. Was decedent pregnant Box ( 3 Ectopic pregnancy
5 Other (specify) for in the past 12 months? Month Dav 1 Yes 2 No cate has been signed by the page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? p Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Minknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate 2 🗌 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director. After this certific completed filled in by the funeral director, **Division of Vital** 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 Yes 2 No 4 Nursing Home 5 Residence 6 N Other (Specify) WOSI W မ 1 Inpatient 2 ER/Outpatient 3 I 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in my articles that have a stated. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signatur and title of certifier 8303 4011 address of person who completed cause of death (Item 23a) (Type, Print) 30. Name and MANUES W AARDN 6701 32. Registrar's Signature Date filed (Month, Day, State

DHMH 17 Rev 7/2009

Registrar

FEB V

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🔱 📗 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 02 Physician/ ANNA 8:45 A.M. LINZ 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A BALTIMORE COUTER 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral 7. Age (In vrs. last birthday) 1 - M 2 KF Days Min. 220-12-8494 **Director** 86 Usual Residence of Decedent Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 28a-f 1X Yes 2 □ No MD N/A Baltimore City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 343 Hornel Street 21224 United States Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc ģ 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give Baltimore, Maryland 21215-0036 er than "natural", to 1 ☐ Yes 2 🛣 No Specify: Specify: Completed 3 ☑ Widowed 4 ☐ Divorced White Year or Dates Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) of Health and Mental Hygiene. Clerical Elementary/Seconday (0-12) College (1-4 or 5+) 10 Years <u>Billing Clerk</u> Department Store injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည George Flury Theodora Nosek 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Peggy A. Messaris(Daughter) 2555 Bynum Overlook Drive Abingdon, MD 21005 Page 1 and 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date permit. Page 1 a Department of H Important: If ite 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sacred Ht. of Jesus Cem. 2/7/11 Baltimore, Maryland Funeral Service Licenses Signature 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ SERSIS SEVERE disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner DIVERTICULITAS ABSCESS MONTH Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Exami Hospital or Attending Physician: The law requires that the death certificate be executed nding physician and use as the burial-transi Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown use 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown for Month Day Year sate has been signed by the page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 2 No Yes after death.

Director: After this certific 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 2 No 1 Yes 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural work? 1 ☐ Yes 2 ☐ No injury 5 Pending 2 Accident 3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by ☐ Homicide determined City or Town, State) Medical 1 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0059114 3 11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MEQUAY, JR. NATHANSEC 4940 AVENUE BALTEMORE. EASTERN 32. Registrar s Signature 31. Date filed (Month, Day, State FEB 0 8 2011 Registrar

Box 68760

P.O.

Records,

**Division of Vital** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 03324 State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Lewandowski Robert Day Physician/ Month 2/5/11 2:29pm M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Gilchrist Hospice Towson Baltimore 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Days 6/8/43 Year) **1X** M 2 □ F Months Hours 219-40-0576 67 Director Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County 10a. State 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10c. City, Town or Location Director MD Baltimore Catonsville 1 Yes ZXNo 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 2014 Rolingwood Road 21228 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Air ned Forces?

\*\*XYes 2 \sum NAtional 1 \sup Yes 2 \times No Specify: Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 white 3XXWidowed 4 ☐ Divorced Year or Dates. Guard marked other than "natu matic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Disabled N/A 12 3+ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Lewandowski ည Naomi Clary 19a. Informant's Name/Relationship (Type, Print)

Amy Trowbridge / Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2014 Rollingwood Rd, Catonsville MD 21228 .8 portant; If item 27 is y injury or other trav 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot
once. Date Glen Haven Cemetery 1 Burial 2 Cremation 3 Removal from State 2/10/2011 Glen Burnie MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Charles L. Stevens Funeral Home, 1501 E. Fort Ave, Baltimore MD 2 Victor Doda 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a conse vence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to for as a consequence of the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death. Cause (Disease or iinjury that initiated events signed by the attending physician and dbe detached for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months? Month Year Day Pregnant at time of death Yes 2 No Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 🖼 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy death? 2 🔽 1 Tyes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending s after death. Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours a 29a. Certifier 🖳 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one title of certifier 29b, Signature ar 29c. License number 29d. Date signed (Month, Day, Year) MD 0 105 D71040 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KUMAR N CHARLEC SUTTE WOS BALTIMORE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 8 aura Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Theresa Helen Lewis February 10:45 P Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Baltimore Timonium Social Security Number 8. Date of Birth (Month, Day, March 28, 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 □ M 2X F Hours 89 Baltimore, Maryland Director 212-18-3162 Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at should be filed within 72 hours after death with the Maryland and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore 1 Yes 2XXNo Parkville 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 2429 Ellis Road 21234 United States 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian "natural", or 1 Never Married 2 Married Completed by 1 Yes 2XXNo If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: 3 X Widowed 4 □ Divorced Specify: White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) N/A Homemaker At Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Walter E. Reitz Almyra Ida Oswinkle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health as Important: If item 27 is any injury or other tra Caren J. Evans 3001 Victorias Way Forest Hill, Maryland 21050 (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) February 08, Donation 5 Other (Specify) Parkwood Cemetery Parkville, Maryland 21. Si natri si un ral Service Licensee 22. Name and Address of Facility Evans Funeral Chapel 8800 Harford Road l & Cremetion Services Parkville Parkville, Maryland 21234 rob 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Cardiovascy Cor Atherosclerotic Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner pertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of requires that the death certificate be executed Cause (Disease or linjury that initiated events attending physician and for use as the burial-tran Due to (or as a consequence of). resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy
5 Other (specify) Month Day Year Pregnant at time of death After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Dementica Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 

Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an To the Hospital or Attending Physician: The law within 24 hours after death. autopsy performed? Yes 2 1 Tyes 2 🗌 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Hospital: Other: ဂ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending injury 1 Yes 2 No ☐ Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifie (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature a License number 120 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2300 DULANEY VALLEY ROAD TIMONIUM MD21093 Tariq Mahmood,

DHMH 17 Rev 7/2009

Registrar

31. Date filed (Month, Day, Year)

FEB 0 5 2011

FEBRUARY

32. Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 5:20 201 Beverly Carol Moran elouan 6 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore Hos betal Agnes If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex Dirthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1 M 2 F 51 Yrs. 212-70-4545 Director May 30, 1959 Maryland Usual Residence of Decedent 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be retified at 10a. State 10b, County 10c. City. Town or Location Director 1 ☐ Yes 🏖 No Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? in and 2 should be filed within 72 hours after death with the Health and Mental Hygiene. 4423 Alan Drive, Apt B 21229 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2√ No If Yes, Give 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 XNo WHITE Specify Completed by 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bartender Food Service 9 item 27 is marked other other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ella O. Ball ္ Robert L. Arnold, Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 414 Hillview Drive, Apt. 204 Linthicum, MD 21090 Ella O. Collins/MOTHER Baltimore, permit. Pages 1 a
Department of He
Important: If item
any Injury or othe 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Denation 5 ☐ Other (Specify) Metro Crematory, TNC: Feb 7, 2011 Baltimore, Maryland ignature of Puneral Service Licensee Patrik, Fleming Cremation Society Of Maryland, Inc. 299 Frederick Road, Baltimore, MD 21228 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Sophageal **Physician** Variceal disease or condition resulting in death) /Medical Due to (or as onsequence of): Examiner 01 LIVER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed res biratory and Due to (or as a consequence of) the attending physician hed for use as the buria Physician/Medical IF FEMALE yes, outcome of pregnancy
Live birth 2 Fetal death
Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1∐Yes 2XNo Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed? 1 □Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? has certificate Vital 1 ☐Yes 2 ☐ No 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2XNo Certification: To 1∑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Division of After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident after death Director: 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 - Homicide 24 hours a 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) P25484 201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print Baltimore himassivastava 900 caton Avenue

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2 2:44 AM 2011 McCoy-Knight Cobun Ricky Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 13altinare Sinai Huspital of Cit Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth Funeral . Age (In yrs. last birthday 9. Birthplace (State or Foreign 1 🛛 M 2 🗆 F Month, Day, 1 29 Country) Director 216-76-4103 50 60 MD Usual Residence of Decedent show 10b. County "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10a. State 10c. City, Town or Location death with the Maryland 10d. Inside City Limits Director MD NA Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21215 3832 Boarman Ave U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, Black, White, etc. Completed by 1X Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examir 1 Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 Specify: Black 1 Yes 2 No Specify: 3 🗆 Widowed 4 🗆 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) llth grade LTD Construction Cd. Construction na Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Alvin Knight <u>Rosetta Jefferson</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Boarman Ave, Baltimore, Md 21215 Rosetta Bullock-Mother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Memorial Park 2/8/2011 Donation 5 Other (Specify) Woodlawn, Md e of Funeral Service Lignsee 21. Skinatu 22. Name and Address of Facility
March F/H West Patient Known 4300 Wabash Ave, Baltimore, Md 21215 23a. Part 1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shick, or hear railure. List only one cause on each line. Approximate Interval Between Onset and Death **3** keeks Immediate Cause (Final Physician/ disease or condition resulting in death) Sepsis Medical Due to (or as a consequence of) Examiner Akute Kidney 2 weeks Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence on the attending physician and hed for use as the burial-transit executed Decubitus Chanic ulcers Centeum that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be a within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia completed filled in by the funeral director, page 2 should be detached for use as the burn Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Pregnant at time of death 2 🗌 No q 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Multiple episode of Meumonia 1 Yes 2 No 3 Probably 4 Onknown Chronic vont dependence due to Quadriplesia 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 100 24a, Was an Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 100 Certificate: To 1: ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) RES 18012 February 2, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

FEB 0 8 201

of Baltimore

Sinai Hospital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) February Day 4:05 AM Physician BRENDA INA MILLER 2011 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner NA Union Memorial Hospital Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Feb. 15 1942 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 10 M 20 F 218-42-4703 Feb. MD Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County itsm 27 is marked other than "netural", or items 23s or 28s-f shov other treumatic event, the Madical Examinar must be notified at 1 TyYes 2 ☐ No Director BALTIMORE MD NA 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 21202 Room 604 2700 N. Charles St. daeth Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours effer c. Depertment of Heelth end Mental Hyglene. Important: if item 27 ie marked other than 'neturei', or item eny injury or other treumatic event, the Medical Expense. 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: À 3 ☐ Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) At Home 11th NA Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Gladys Talbot Arthur Hope ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Vonita Wilson - Daughter 21217 2631 Francis Street Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) On-Site Cre. Cnt.02/08/11 Baltimore, MD e of Funeral Service Licensee 22. Name and Address of Facility 4300 Wabash Ave. March Funeral Home West, Inc. 23a. Part1. Enter the disease, or complications that seased the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Balto., MD 21215 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner ettending physicien end for use as the burlei-trensit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Year in the past 12 months? Month Day 5 ☐ Other (specify) been signed by the should be deteched 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part Jk. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? this certificate has 1 ☐ Yes 2 ☐ No 0 1 Yes □No spital or Attending Physician: Thours efter deeth.
Ineral Director: After this certificet
y filled in by the funerel director, pe Was referred to make examiner? 8 25. Was 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ို 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 28b. Time of Certification; 5 Pending Natural 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours e To the Funeral ( Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b Signature and title of certifie 29d. Date signed (Month, Day, Year) enrua 121 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 45 Bruce 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death 5<sup>Day</sup> Physician/ Month Feb. 201<sup>Year</sup> 6:15 P M Elizabeth Anne Murdock Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Broadmead Cockeysville . Social Security Number If Under 1 Year If Under 24 Hrs. Funeral 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 TF March 21 Country) Director 77 218-32-9400 Usual Residence of Decedent 10b. County hours after death with the Maryland r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 ☐ No MD Baltimore Cockeysville 10e. Street and Numbe 10f, Zip Code 10g. Citizen of What Country? Funeral 13801 York Rd. 21030 USA S306 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. Completed by 1 Never Married 2 X Married Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. Specify: white 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene. Is marked other than life. DO NOT use retired) Mechanical Elementary/Seconday (0-12) College (1-4 or 5+) Contracting n/a Treasurer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, 2 Page 1 and 2 should be Otis Dewlin Bessie Marie Campen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) it of Health a Bruce P. Murdock/husband 13801 York Rd., S305, Cockeysville, MD 21030 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Dulaney Valley
Memorial Cardens 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Dulaney permit. Page Department of Important: If any injury or once, 2/9/11 4 ☐ Donation 5 ☐ Other (Specify) Timonium, MD 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley, Inc. 10 W. Padonia Rd., Timonium, MD 21093 21. Signature of Funeral Service Licenses Flag 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner TRUCTIVE TULMONARY DISEAS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner signed by the attending physician and defached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Be Completed by Physician/Medical f yes, outcome of pregnancy

☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
☐ Pregnant at time of death 5 ☐ Other (specify) \_\_\_\_ 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? the Hospital or Attending Physician: The law requires 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 12 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural injury 5 Pendina Division 1 ☐ Yes 2 ☐ No Accident Investigation within 24 hours after deat To the Funeral Director: 6 Could not be ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ <sup>Day</sup> 2011 Feb. 6:17 A M Mary Feihe Moore Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 26 Clubview Lane Baltimore Phoenix 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs Months Days Hours Min. Funeral 8. Date of Birth Date of Day, (Month, Day, 9. Birthplace (State or Foreign Days 1 M 2 XF Months Country) **Director** 59 217**-**58-5349 Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Completed by Funeral Director 1 ☐ Yes 2x No MD Baltimore Phoenix ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a 26 Clubview Lane 21131 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force: Black, White, etc. "natural", or 1 Never Married 2 🙀 Married and 2 should be filed within 72 hours after ☐ Yes 2 🔀 No Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 🙀 No Specify: white 3 Divorced Specify: Year or Dates Il Hygiene. other than "natura vent, the Medical E 15. Decedent's Education 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)
Director of Operations for 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Loyola University 5+ undergraduate Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) marked ဂ Charles H. Feihe Frances Rouchard 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) S Health tem 27 G. Edward Moore 26 Clubview Ln., Phoenix, MD 21131 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of IImportant: If ite
any injury or ot 20c. Location - City or Town, State February 6, cemetery, crematory or other place)
Atlantic Crematory 1 Burial 2 X Cremation 3 Removal from State Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 2011 21. Signature of Puneral Service Licensee 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley, Inc.
10 W. Padonia Rd., Timonium, MD 21093 Michael JC **Flagie** 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onkel and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, in the cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (bries a consequence cry sician and burial-transit Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box ( 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death 5 Other (specify) Month Day Year ate has been signed by the page 2 should be detached 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No 1 🗌 Yes 2 🗀 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?

1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director; After this 28a. Date of injury (Month, Day, Year) completed filled in by the funeral Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury Accident Investigation 1 Yes 2 No 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 🔲 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier

Registrar

State

who completed cause of death (Item 23a) (Type, Print)

R097025

Orleans St, David Koch Bldg, SUITE IM-16, Balto, HD 2123

	Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.  State of Maryland / Department of Health and Mental Hygiene											
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t of He If iter or oth		20a. Method of Disposition  1  Burial 2  Cremation	3 ☐ Removal from State		lace of D e <i>metery</i> ,	isposition (Na crematory or	me of other plac	ce)	Date	20c.	Location - City or 1	own, State
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		4 Donation 5 Other (S		Hil	1top			orp. 2-4			wson, Ma	
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To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director, After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the but the but the funeral director page 2 should be detached for use as the but the but the funeral director page 2 should be detached for use as the but th	by	Part II. Other significant condition	ons contributing to death I	out not resu	ulting in t	he underlying	cause giv	ven in Part I.			_/_	the cause of death?
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60		30. Name and address of person	who completed cause of d	death (Item	23a) (Typ	pe, Print)		6876	) Harr	Atio	1 Amict	\$106A 21237
Stat		31. Date filed (Month, Day, Year)	32. Registr	ar's Signat	ure	TVT.			1111	1161	11-11-11	1-1/11 · K4()
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MCKIM Month Vear AMES 1025 AM 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Randallstow North WEST HOSPITZ Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye Jan 2, 1 . Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🙀 M 2 🗆 F Days Min. Months Hours Maryland Director 81 1930 219-28-3921 Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2X No MD Baltimore Pikesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9 Church Lane 21208 U.S.A 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?
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Department of H
Important: If ite
any injury or ot 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) St. Charles Cemetery 2/11/11 Pikesville, Maryland 22. Name and Address of Facility 11824 Reisterstown Road 21. Signature of Funeral Service Licensee ren Eline Funeral Home Reisterstown, MD 21136 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween Immediate Cause (Final Onset and Death Ph sician/ Sepsis disease or condition Medical resulting in death) Examiner Abdomi Sequentially list conditions, if any cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine physician and s the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Day Pregnant at time of death 5 Other (specify) 1 Yes 2 L 9 Unknown 9 Unknown P.O. I þ s been signed b should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 24a. Was an After this certificate has autopsy director, page 2 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Yes 2 No ျ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) filled in by the funeral 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 24 hours after death Funeral Director: A Accident Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the within 2 To the only one 29b. Signature and title of certifier 2 29c. License number 29d. Date signed (Month, Day, Year) D65843

DHMH 17 Bev 7/2009

State

Registrar

Abdallah

31. Date-filed (Month, Day, Year)

EEB 0 2 201

5401

32. Registrar's Signature

old Court Road, Randallstown, HD 21133.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 1tem 1 per doc g912 2-11-11 yt
State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) James R. Mask 2. Date of Death 3. Time of Death Month Physician/ 3:20 a 2011 - James F. Mask <u>February</u> 6, Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death <u>Baltimore</u> Futurecare Cherrywood Reisterstown If Under 1 Year If Under 24 Hrs. Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** (Month Day, Year) an 11, 1930 Mary Land 1 X M 2 - F Months Days Director 81 212-24-6861 Usual Residence of Decedent or 28a-f show notified at 10a, State 10b. County 10d. Inside City Limits within 72 hours after death with the Maryland 10c. City, Town or Location Director 1 Yes 2 No MD Baltimore Reisterstown 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? er than "natural", or items 23a of the Medical Examiner must be Funeral 123 Charguer Road 21136 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?
1 

Yes 2 □ No Black, White, etc. ģ 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: If Yes, Give 3 Widowed 4 Divorced Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Surveyor Land Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Bowers Anna Henry Joseph Mask 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan R. Mask Wife 123 Charguer Road Reisterstown, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🗓 Cremation 3 ☐ Removal from State Carroll Cremation 2/7/11 4 Donation 5 Other (Specify) Hampstead, Maryland 22. Name and Address of Facility 11824 Reisterstown Road Signature of Funeral Service Licensee m hen Le Eline Funeral Home Reisterstown, Maryland 21136 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Retween Onset and Death Immediate Cause (Final Viseuse Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) use as the burial-tran been signed by the attending physician and should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Dav Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 Ho 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? page 2 this certificate has To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဂ္ 1 Yes 2 🔁 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 📈 Natural 5 Pending work?
1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 737373 7,2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10v **21209** Are MD ZIA

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Maryland 21215-0036

Baltimore,

Box 68760

P.0

Records,

Division of Vital

32. Registrar's Signature

Division of Vital Records, P.O. Box 68760
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1 - State of Maryland / Department of Health and Mental + Certificate of Death  1. Decedent's Name (First, Middle, Last)	201103334
Togistic.	
	Reg. No.  Death 3. Time of Death
Physician/ Medical Rebecca Linthicum Meseke Feb.	4, 2011 Year 9:50 P M
Medical Examiner  4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death	4c. County of Death
North Arundel Health & Rehab Center   Glen Burnie	Anne Arundel
Funeral 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Months Days Hours Min. Months Days Hours Min. Tudy	Day, Year) Country)
Ulsual Residence of Decedent	6, 1922   Maryland
	10d. Inside City Limits
TO TO SEE Maryland Anne Arundel Linthicum	1 ☐ Yes 2 🛣 No
The politic of the po	10g. Citizen of What Country?
R R R R R R R R R R R R R R R R R R R	USA
11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	No- 14. Race - American Indian, Black, White, etc.
1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates.	Specify: White
The state of the s	16b. Kind of Business Industry
(Specify only highest grade completed)  (Give kind of work done during most of working life. DO NOT use retired)  (Give kind of work done during most of working life. DO NOT use retired)	
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O   O	
Hezakiah Linthicum Elli Cul  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Num	pher City or Town State Zin Code
Edward Meseke/Son 1808 Twin Oak Rd Jarrettsv	
20b. Place of Disposition (Name of Feb Date 9	20c. Location - City or Town, State
1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify)  Clen Haven MEM Park 2011	Glen Burnie MD
21. Signature of Funeral Service Licensed 22. Name and Address of Facility Singleton	
The state of the s	
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirator shock, or heart failure. List only one cause on each line.	/ arrest, Approximate Interval Between
Physician/ ) Medical Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of):	Onset and Death
Medical resulting in death)  Examiner  Due to (or as a consequence of):	
Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):	
pan property and the property of the property	
d.    FFEMALE: 23b. Was decedent pregnant in the past 12 months?   1   Ves 2   No   9   Unknown   2   Unknown   2   Unknown   2   Ves	
23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy  1	23d. Date of delivery  Month Day Year
9	
pour part part part part part part part par	id tobacco use contribute to the cause of death?
se sign properties 1	☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown
The law reduines the page of t	/as an 24b. Were autopsy findings available prior to completion of cause of
The kapengaran are har	erformed? death? es 2 No 1 Yes 2 No
25. Was case referred to medical examiner?	
Open Section   Position   Posit	esidence 6  Other (Specify)
27. Manner of Death 1 Natural 5 Pending 1 Nestigation 3 Suicide 4 Homicide 28a. Date of injury (Month, Day, Year) 28b. Time of injury M 1 Yes 2 No 28d. Description 28d. Injury at work? 1 Yes 2 No 28d. Description 28d. Descripti	pe how injury occurred
2 Accident Investigation 3 Suicide 6 Could not be determined determined determined determined	n (Street and Number or Rural Route Number,
Description of the control of the co	Town, State)
29a. Certifier  29a. Certifier  29a. Certifier  29a. Certifier  25a. Certifier  25a. Certifier  25b. Medical Examiner: On the basis of examination and/or investigation in my opinion death occurred at the time, date and place, and due to the	
29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the control only one)  29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the control only one)  3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the control only one)	
only one) 3 Li Certifying Nurse Practioner: 10 the best of my knowledge, death occurred at the time, date and place, and due to 29b. Signature and title of certifier 29c. License number	29d. Date signed (Month, Day, Year)
D-40521	29d. Date signed (Month, Day, Year) February 7, 2011
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MAKESK S. OCHAN	29d. Date signed (Month, Day, Year) February 7, 2011 Eym. D.
D-40521	29d. Date signed (Month, Day, Year) February 7, 2011 Eym. D.

DHMH 17 Rev 7/2009

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			State of Maryland / Department of Health and Mental Hygiene  1 - State Registrar  Certificate of Death  Reg. No.														
			Registrar  1. Decedent's Name	/First Middle	( act)			Certifica	ite of L	eatn_		2. Date of Dea	Reg. No	э.		3. Time of	Dooth
	Physicia Medic		Edgara	,	, Lasi)		Moody					Month Februa	Da	2, 20	Year 11	18:25	
Ma.	Examin	er	4a. Facility Name (if		_		_		ty, Town, or				4c. County of Death Anne Arun			. 1 . 1 . 0	
1	<u></u>		7900 Get 5. Social Security No		eeze Ct.	Apt B Glen Burni  7. Age (In yrs. last birthday) If Under 1 Year I f Under					_	8. Date of Birt	th			lace (State o	
	Funeral Director		216-36-7	751	1 □ M 2 🔀 F						Min.	8. Date of Birt (Month, Da June 6	y, Year) 19:	38	Count		
	how at	F	Usual Residence of 10a. State	Decedent 10b. County		1	0c. City, Tow	n or Location			-,-				10	Dd. Inside Ci	ity Limits
	arylaı a-fs ified	Funeral Director	MD Anne Arundel Co. Glen Burnie											1 🗌 Yes	2 X No		
	or 28	Ē	10e. Street and Num	nber				10f.							Citizen of What Country?		
	with t	eral	7900 G	entle I	Breeze Co	urt,	Apt B		2106	1			1	Unite	d St	ates	
	tems er mu	F	11. Marital Status		12. Was Dec	edent Eve		13. Was Dec	edent of Hi	spanic Ori	gin? (Spec	ify Yes or No-		14. Race			
336	1 and 2 should be filed within 72 hours after death with the Maryland if Health and Merital Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by	1 ☐ Never Marri		ied Armed F 1 Yes If Yes, Gi Year or D	2 🔀 No ive			Yes, specify Cuban, Mexican, Puerto Rican, etc.)  ☐ Yes 2【 No Specify:						Black, White, etc.  Specify: White		
9800-15 in the first of the superior of the su									sual Occupa	ation			16b. l	Kind of Bus			
(Give kind of work done during most of working life. DO NOT use retired)  College (1-4 or 5+)									g	S	ocial	Sec	urity				
The property of the property o															stra	tion	
Maryland	be filed tental Hygred other ic event	17. Father's Name (First, Middle, Last)  18. Mother's Name (Part Miller Long Mario:											,				
S	should be file h and Mental H 7 is marked of traumatic ever	Edgar Miller Long Marjory E.  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Nurr										. Deal					
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	and 2 s Health s tem 27 i		Mr. Doug		Hinklema	_		5406 Bu		us Ko		Pasade		Mary ocation - 0			
nor	age 1 ent of nt: If it y or o		1X Burial 2	Cremation	3 Removal from	n State	cemete	ry, crematory o	r other plac						,		
Baltimore,	permit. Page 1 and 3 Department of Healt Important: If item 2 any injury or other		4 Donation 5 Other (Specify)  Glen Haven Mem. Park 2/9/2011  Glen Bu  21. Signature of Funeral Service Licensee  22. Name and Address of Facility Singleton Funeral  Comment of Park 1 2 and 2 a										& Cr	ematio			
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-	Physician/ · Medical		shock, or hear Immediate Cause (I disease or condition resulting in death)	t failure. List c =inal	nly one cause on e	ach line.	25104	arter	0-5	Elia	otic	Card	lov	lusen	lie	Approximat Interval Bet Onset and I	ween
25	Examiner		resulting in death)	ï	Pyle to	(or as a c	onsequence	of);	Drie	ase					ľ		
		jer	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or infinity)  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):												_		
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90	cate be executed physician and s the burial-transit	edical		7	d										$\perp$		
Box 68760	tifical ing ph as th	Mec	IF FEMALE:										T				
9 ×	eath certific attending p	ian/	23b. Was decedent in the past 12 p			Birth 2	Fetal death	3 Ectop		У				23d. Date Mont			Year
Bo	or Attending Physician: The law requires that the death certificate be executed after death.  Director: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transi	Completed by Physician/M	1 Yes 2 15 9 Unknown	No	9 Unk		me of death	5 ∐ Other	(specify)					1410111			
of the first of th								ute to th	e cause of d	eath?							
ds,	quires en sig auld b	ted	Day	maca	.0079							1 🗆	Yes 2	□ No 3	3 🗌 Prob	ably 4 🔀	Unknown
24a. Was an autopsy perform												available ause of					
Re	The la	ĕ											rmed?	de	eath?	-	
<u>a</u>	ysician: The is certificate Is director, page	Be (	25. Was case referre examiner?	d to medical					26. Pla	ace of Dea	th (Check o	only one)					
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ام	ling F	ate	<ol> <li>Manner of Death</li> <li>Natural</li> </ol>	5 🗆 Pendin	9 '	of injury oth, Day, Y	(ear) 28b. i	Time of njury	28c. Injury work	?		3d. Describe h	now inju	ry occurred	i		
<u> </u>	death death ctor: /	Certificate:	2 Accident 3 Suicide	Investion 6 Could	not be	e of Injury	- At home fa	rm, street, fact	<u> </u>	Yes 2 L		8f. Location (S	Street or	nd Number	or Rural	Route Numb	nor
Division of Vital Records,	al or A s after I Direct	Cer	4  Homicide	determ		ling, etc. (S		in, street, last	3ry, <b>3</b> moo			City or Tow			or ribrar.	riodie rybriib	161,
29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place,								ccurred at the	he time, date a	and place	e, and due t	to the cau	se(s) and ma	inner stater			
	orthe orthe	Σ	only one) 3 29b. Signature and		Nurse Practioner	: To the bes	st of my know		9c. License	number		and due to the		s) and man ate signed (			
	->-0		1	Der.	M	).			DO	428.	20		2	3	1)	,	
	Le V		30. Name and addre	ss of person v	vho completed cau	se of deat	h (Item 23a) (	Type, Print)									
	Q V		Christ	opher			a.m.D	. 370	8 n	JOUR	tair	Rd	P	asc	den	a mb	318
7	Stat		31. Date filed (Month				Signature										
	Registra	ır	I PO O	2011	Clevery	4.	Some	lad .									

Registrar DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND ITEM# | perpHYS, G912, 2/872011, WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 02 Physician/ Year 1.50 AM David Margola David Marzola 04 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford Upper Chesapeake Medical Ctr Bel Air 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 ☐ F Months Days Hours Min. (Month, Day, Year) 7-5-1938 Country) Director 219-32-0531 MD Usual Residence of Decedent show or 28a-f shov notified at 10a. State 10b. County 10d, Inside City Limits within 72 hours after death with the Maryland Director 10c, City, Town or Location Baltimore Middle River 1 Yes 2 No ΜD 10e. Street and Number 10f, Zip Code 10g, Citizen of What Country? "natural", or items 23a or edical Examiner must be Funeral USA 2130 Cockspur Road 21220 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 No Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. White 1 Never Married 2 Married X Widowed 4 Divorced ģ 1 ☐ Yes 2 H No Specify: If Yes, Give Year or Dates. Completed the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working (Specify only highest grade completed) of Health and Mental Hygiene. Item 27 Is marked other than other traumatic event, the Me life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Automobile Sale Car Sales Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t. Page 1 and 2 should be fill timent of Health and Mental tant: If item 27 is marked or မ Caroline Perni Dominick Marzola 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2130 Cockspur Road, Middle River, MD 21220 Catherine Marzola - wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 Department of Important: If it any injury or o 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) Atlantic Crematory 2-8-2011 Glen Burnie, MD 21. Signature of Fine al Sevice License 22. Name and Address of Facility Bradley-Ashton Funeral Homa 2134 Willow Spring Road 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 24 mRS Immediate Cause (Final Physician/ ACUTE MYOCGARDIAL INFARCTION disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner ARTERY CORONARY DISENSE Sequentially list conditions, Examine Due to (or as a consequence of, If any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events the attending physician and hed for use as the burial-transit I or Attending Physician: The law requires that the death certificate be executed after death.

Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of) resulting in death) Last Physician/Medical Marzola David M/80053874 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day 2 🗆 No 1 ☐ Yes 2 ☐ Unknown a Unknown To the Funeral Director: After this certificate has been signed by completed filled in by the funeral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by RENAL FAILURE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown CHRONIC OBSTRUCTIVE LUNG DISEASE. 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death?
1 Yes 2 No DIABSTES MELLITUS 2 No Yes Be ( 25. Was case referred to medical examiner? 26. Place of Death (Check dnly one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No Certificate: To 1 Unpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Hospital of 24 hours a within 24 hours a To the Funeral C Medical 29a. Certifier 🖆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Certifying Physician: to the basis of examination and/or investigation, in my opinion, death procurred at the time, date and place, and due to the cause(s) and manner stated.

Continue Physician: Nurse Practices: 1 to the basis of examination and/or investigation, in my opinion, death procurred at the time, date and place, and due to the cause(s) and manner stated. (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) FEB 4TH 2011 D021207 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 MIDCREST CT. BALTIMORE, MD 21286 FRANZ C. VELLA - CAMILLER' MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 7/2009

Registrar

FEB 0 0 2011

Division of Vital Records, P.O. Box 68760	
To the Hospital or Attending Physician: The law requires that the death certificate be executed	ecuted
<ul> <li>Within 24 hours arrect death.</li> <li>To the Funeral Director: After this certificate has been signed by the attending physician and committed filled in but the funeral director, nano 2 should ha datached for use as the burish-transit</li> </ul>	and

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	4	For State	State of M	arylan		partment of F ertificate of D			- Com		03337
		Registrar  1. Decedent's Name (First, Middle, La	st)		CE	er tillicate or L	)calli	2. Date of Dea	Reg. No. th		3. Time of Death
Physician Medica		Theresa				Murphy		Februar Februar	Ty 6,	2011	8:30 P M
Examine		4a. Facility Name (if not institution, give Genesis Eldercare		e Cen	ter	4b. City, Town, or Dunda	Location of Death		4c. County of Death Baltimore		
Funeral Director		5. Social Security Number 6. 3			ast birthday	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day September	3, 191	9. Birth	nplace (State or Foreign Intry) Sylvania
3	, t	Usual Residence of Decedent  10a, State 10b, County						.Tk			10d. Inside City Limits
Maryland 28a-f sh otified a	Irecto	Maryland Baltin	ore	Tue, City	, Town or L Du	ndalk					1 Yes 2 XNo
th with the Maryland ms 23a or 28a-f show must be notified at	Funeral Director	10e. Street and Number 8133 Murray Point	Road			10f. Zip Code	21222	:	10g. Citizen <b>US</b>	of What Cou A	untry?
death item:		11. Marital Status	12. Was Decedent I Armed Forces?	er in U.S	3. 13	. Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puert	pecify Yes or No- o Rican, etc.)		Race - Amer Black, White	
urs after ural", or	Completed by	1 ☐ Never Married 2 ☐ Married 3 🎇 Widowed 4 ☐ Divorced	1  Yes 2 If Yes, Give Year or Dates.	<b>≬</b> lo		1 ☐ Yes 2 ☐XNo	Specify:			cify: Whi	
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within giene. er tha	ទី	12 years	College (1-4 or 5	5+)		Housewife			Ow	n Home	e
l be filed lental Hy rked oth tic event	lo Be	17. Father's Name (First, Middle, Last) Robert Shipe						ne (First, Middle, 1 Dulaney	Maiden Sum	ame)	
12 should alth and M 27 is ma r trauma		19a. Informant's Name/Relationship (1806) Murphy	Type, Print) Son			iling Address (Street a					
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1   → Burial 2   → Cremation 3   → Donation 5   → Other (Special Control of the Con		C	emetery, cr	position (Name of ematory or other place n Cemetery		uary , 2011		on - City or 1	ryland
permit. F Departm Importa any injui	ŀ	21. Signature of Foneral Service Licen	-2-0			22. Name and Address Connelly I 7110 Solls					
	$\dashv$	23a. Fart 1 Enter the disease, or com	and a service and a sealer than	-	n. Do not er	nter the mode of dyin	g, such as cardiac	or respiratory arre	est,		Approximate
Physician/		Immediate Cause (Final disease or condition	CHR	 DKU.	( 1)	BSTRUC EDE	111/6	PHIMA	ARY	DKEA	Interval Between Onset and Death
⊢ Medical Examiner		resulting in death)	Due to (or as	a consequ	ence of):		-1.0		73.27	ZNO	
		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as	a consequ	ence of):	EDE	MENT	/H			
= 13. a 6		Cause (Disease or linjury that initiated events resulting in death) Last	c. Due to (or as	a consequ	ence of):						
ate be	dical		d								
certific inding use as		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome 1  Live Birth 4  Pregnant a 9  Unknown	2 Feta	death 3	☐ Ectopic pregnanc☐ Other (specify)	у		23d.	Date of deli Month	very Day Year
To the Hospital or Attending Physician: The law requires that the death within 24 hours after cleath.  To the Funeral Director: After this certificate has been signed by the attention completed filled in by the funeral director, page 2 should be detached for the director for the funeral director.	≥	Part II. Other significant conditions	contributing to death b	out not resi	ulting in the	underlying cause giv	ven in Part I.				the cause of death?
require been should	leted							24a. Was a		4b. Were aut	opsy findings available
The law	Сотріете							autop perfor 1 🗌 Yes	med? 2 No	prior to c death? 1 Yes	ompletion of cause of 2 No
certific rector,	e	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:			Oth	ace of Death (Che				
g Physical this neral different	<u>.</u> 	27. Manner of Death	1 ∐ Inpati 28a. Date of inju (Month, Da	ry	ER/Outpati 28b. Time Injury	ent 3 LJ DOA of 28c. Injun	4 Nursing F	lome 5 Residence 28d. Describe ho			fy)
tendin death. tor: Aft the fur	Certificate:	1 ✓ Natural 5 ☐ Pending 2 ☐ Accident Investigatio 3 ☐ Suicide 6 ☐ Could not be	n			M 1 🗆	Yes 2 No				
ital or Attendi urs after death ral Director: A led in by the fu											
To the Hospital within 24 hours To the Funeral completed filled	Medical	(Check 2 Medical Exam	rsician: To the best of niner: On the basis of e rse Practioner: To the	xamination	and/or inve	estigation, in my opinio	on, death occurred	at the time, date ar	nd place, and	I due to the c	ause(s) and manner stated.
Not vith Corr		29b. Signatore and title of certifier	nleTu	lue	. N	29c. License				gned (Month,	
HV		30 Name and address of person who	completed cause of d	eath (Item	23a) (Type,	Print)	Place	Dun	dall	MI	0 21222
State Registrar		31. Date filed (Month, Day, Year)	32. Pagistra	ar's Signat	ure	all					
	_		UII CERCE	-	- //						

03333 State of Maryland / Department of Health and Mental Hygiene? State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February 2011 10:15 P M Albert Finley Mears. Sr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Edenwald Towson 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs, last birthday) Funeral Year 19<u>31</u> ine 26, 1 **X** M 2 □ F Months Days Hours Maryland Jüne **Director** 219-28-0092 Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits 10a, State 10b. County 10c. City. Town or Location Director 1 Yes 2 XNo Maryland **Ealtimore** Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21093 U.S.A. 132 Greenmeadow Drive 12. Was Decedent Ever in U.S. Armed Forces?

1 1 4 Yes 2 1 No If Yes, Give 1953 – 1955 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black White etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 👿 No Specify. Specify: 3 X Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Ma Life Insurance Elementary/Seconday (0-12) College (1-4 or 5+) Underwriter Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Grason Finley Marguerite 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21286 Albert F. Mears, Jr. SOn 1434 Putty Hill Avenue Towson, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cometer), crematory or other place)
Dulaney Valley
Memorial Gardens 20c. Location - City or Town, State ⊠ Burial 2 ☐ Cremation 3 ☐ Removal from State Donation 5 Other (Specify) 2-10-2011 Timonium Maryland 21. Signat eral Service Licensee 22. Name and Address of Facility Ruck Towson Funeral Homes, Inc. 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ PUS disease or condition resulting in death) Medical Due to (or as a donsequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): that the death certificate be executed burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical the use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Year Pregnant at time of death Month Day signed by the a be detached t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? 2 🗌 No Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 Yes 2 No Investigation 3 Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) e and address of person who leted cause of death (Item 23a) (Type, Print) Cho 31. Date filed (Month, Day, Registrar

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DHMH 17 Rev 7/2009

Box 68760

Records,

Division of Vital

		Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.  State of Maryland / Department of Health and Mental Hygiene												
		-	For State Registrar	State of	Mary		partme ertificat			Mental Hy	giene Reg. No	201		03339
ı	Physicia	ın/	Decedent's Name (First, Middle	e, Last)					<u> </u>	2. Date of De		ay '	Year	3. Time of Death
	Medic	cal	4a. Facility Name (if not institution	Mack		Allen	4b, City		e Jr. Location of Death	Feb. 2011  4c, County of Death			/ +.M.	
	Examin	ier	2611 North S				40. 010		emere	Baltimore				re Co.
	Funeral Director		5. Social Security Number 212–34–5993	6. Sex 1 🔀 M 2 🗆 F	<sup>7</sup> . Age ( <i>ln y</i>	rs. last birthda Yrs.	Months	Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, Da April	9. Birthpl Count	ace (State or Foreign ry) land		
			Usual Residence of Decedent											
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the M	or 28; e noti	Dire	MD Ba  10e. Street and Number	ltimore		Edgemer 10f. Zip Code					10g. Citizen of What Co			try?
h with	ns 23a nust b	Funeral	2611 North S		_	21219					United Sta			
fter deat	, or iten aminer i	þ	11. Marital Status 1— Never Married 2 ☐ Mar	If Voc Give	ces? 2 🛣 No	1 U.S. 1		spanic Origin? (Sp n, Mexican, Puerto Specify:	pecify Yes or No- o Rican, etc.)				tc.	
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thin 72 h	ene. than "n he Medi	Completed	(Specify only high Elementary/Seconday (0-12) 10 Years	4 or 5+)	(Gi life	ve kind of wo DO NOT us achine	ork done a se retired)	furing most of wor	<i>kin</i> g		lson			
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ed bla	Ment marker natice	인								Virginia Brodus  ling Address (Street and Number or Rural Route Number, City				
od 2 sho	aalth and m 27 is r eer traun		Joyce Wallenho		e)				y Road					21015
Page 1 a	Department of Health and Mertial Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 Ⅺ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (	3 ☐ Removal from Specify)	State		rematory or	Cemetery 2/5/2011 Baltin						wn, State Maryland
permit	Departr Importa any inju		21. Signature of Funeral Strice Licenste  22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk 7922 Wise Ave. Dundalk, Maryland										ılk,	Inc. 21222
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that th	gned by e detac	by Ph	Part II. Other significant conditi	rt II. Other significant conditions, contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to								-		
equires	been sig	eted	4000V19ac	quy nrw		CYCCC								ably 4 Unknown
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	21.0		> Forest?	aut 1	N		5	039	rielec	)	Fun	NOON	14	2011
1	5 V		30. Name and address of person	who completed cause	of death	(Item 23a) (Typ	e, Print)	J 1	Bellin	פאכם. נא	Ai)	20	19	
	Stat Registra	te	31. Date filed (Month, Day, Year) FEB 0 8 2011	32. Re	gistrar's Si	ignature	,	- 10	TOTAL IT VA					
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	Dhusisis	/	1. Decedent's Name (First, Middle, La	,		timodic or Dodi	2. Dat	Reg.	****	3. Time of Death	
	Physicia Medi	cal		A. McLyman					<b>1</b> , 20 <b>11</b>	12:26 Рм	
	Examir	ner	4a. Facility Name (if not institution, giv 71 Wise Ave			4b. City, Town, or Locat  Dundalk	ion of Death		4c. County of Dea Baltimon		
	Funeral	г	5. Social Security Number 6. 8	Sex 7. Age (In	yrs. last birthday)	If Under 1 Year If Un	nder 24 Hrs. 8. Dat	e of Birth	g. Bir	thplace (State or Foreign	
	Director		216-16-8115 Usual Residence of Decedent	1 XM 2 □ F 87	Yrs.	Months Days Hou	rs Min. (Mc Apr	il 30,	1923 Ma	ryland	
	and show at	5	10a. State 10b. County	100	c. City, Town or Loc	ation				10d. Inside City Limits	
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	th the 3a or t be n	a D	10e. Street and Number			10f. Zip Code		· 10g.	Citizen of What Co	ountry?	
	ems 2	Funeral Director	71 Wise Ave.	12. Was Decedent Ever in	in U.S. 13. V	21222 Vas Decedent of Hispanic	Origin? (Specify Yes		ites Sta		
Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ρ	1 ☐ Never Married 2 ☐ Married  ③XXWidowed 4 ☐ Divorced	Armed Forces? 1 XYes 2 No If Yes, Give Year or Dates. WW I.	If	Yes, specify Cuban, Mex  Yes 2 X No Spe	ican, Puerto Rican, e	etc.)	Black, Whit		
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Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Mont 02 06 2011 12:45 Macomber ам R. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Gilchrist Hospice Center Towson Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours 1 X M 2 - F Mo71971923 Director 219-18-1082 87 MY Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 💢 No MD Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 7906 Ridgely Oak Road 21234 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces' Black, White, etc. Completed by 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: is marked other than "natural", 3 Widowed 4 Divorced Year or Dates WII White traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Mechanical Engineer Federal Gov't. 12 4 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Macomber Bertha Mae Sinsabaugh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 s Health ( 12442 Jerusalem Road, Kingsville, MD 21087 Robin W. Beers, Daughter permit. Page 1 and:
Department of Healt
Important: If item 2
any injury or other t 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 02/11/2011 Baltimore, Maryland Moreland Memorial Park 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Leonard J. Ruck, Inc. lexandra 5305 Harford Road, Baltimore, MD 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Linter Underlying equence of): Examir Cause (Disease or linjury that initiated events that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Records, 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autonsy Yes 2 W 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Division of Vital director, Be 26. Place of Death (Check only one) Hospital: Other: 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Sether (Specify) this 28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28d. Describe how injury occurred To the Hospital or Attending Natural 5 Pending iniurv work? 1 🗌 Yes 2 🗌 No thin 24 hours after death.

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3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signatj 29d. Date signed (Month, Day, Year, 06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NCHAR ionth, Day, Year, 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

DHMH 17 Rev 1/2001

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31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Margaret R. Marriott Month 2 PM February 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 410 Montemar Avenue Baltimore Catonsville 8. Date of Birth
(Month, Day, Year)
Nov. 2. 1940 Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. Maryland 217-38-0454 Director Yrs 70 Usual Residence of Decedent th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f shor traumatic event, the Medical Examiner must be notified at 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Catonsville 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21228 Montemar Avenue USA within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. <u>}</u> 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Year or Dates White Specify. 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be be filed v 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Matthew Reily Josephine Marie Ridgely 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trau Cynthia Bledsoe - Daughter 410 Montemar Ave., Catonsville, MD 21228 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery/srematory or other place) 20c. Location - City or Town, State Burial 2 X Cremation 3 Removal from State Feb.11,2011 Atlantic 🔲 Donation 🖁 5 🔲 Other (Specify) Crematory Glen Burnie, MD e Service License 22. Name and Address of Facility Ambrose Funeral Home, Inc. Signat 1110 1328 Sulphur Spring Rd., Arbutus, MD 21227 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final atteropelentic Cardiavardle Discen Physician/ year Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Due to for as a consequential of if any leading to immedia cause. Enter Underlying Cause (Disease or linjury or Attending Physician: The law requires that the death certificate be executed and tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months? Month Day Year ed by the a detached f 2 No g Unknown 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ / Lotastarola 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown Completed director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No certificate I 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 2 1 No Other: 1 Yes ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Natural injury 5 Pending ☐ Accident ☐ Suicide Investigation To the Funeral Director, completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined To the Hospital 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State

31. Date filed (Month, Day, Year, FEB 0 8 2011 Registrar

Charles K

M.P. 001 32. Registrar's Signature

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29d. Date signed (Month, Day, Year)

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29c, License number

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

1 1 We

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 45A.M 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 3999 ERRACE HAMPSTEAL ARROL 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Sex. 1 M 2 □ F Country) MARYLANS Days (Month, Day, Year 8 Months Yrs. **Director** or items 23a or 28a-f shov 10a. State permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No HAMPSTEAD 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 3990 210 FRRACE 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 No 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Union meer ocal Be 17. Father's Name (First, Middle, Last) 18. Mdther's Name (First, Middle, Maiden Surname) မ MOORE Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MOORE ethod of Disposition 20b. Place of Disposition (Name of cemetery crematory or other pla Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 5 12011 YORKED, MONKTON ND ZHII Signature of Funeral Service Lios 1201 4 (REMATION. Part 1. Enter the dise s or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. 23a, Part 1, Enter the dise s Approximate Interval Between set an Dent Immediate Cause (Final disease or condition resulting in death) Enysician Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner Due to (or as a cor the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_ in the past 12 months?
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4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check **Gertifying Nurse Fra** 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Satah FrattaliMD 423/ Northi 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death February 3, 201 Physician/ Ellen Richards Metzbower 5:20 Ам Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Parkville Oak Crest Care Center Baltimore Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Days 1 🗆 M 2 🗐 🕂 F Months Hours Sept. 75,1918 Virginia 212-09-3147 Director 92 Usual Residence of Decedent shov ral", or items 23a or 28a-f sho Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Director Parkville Baltimore MD 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21234 8810 Walther Blvd Apt. 1516 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: white "natural", 3 ₩ Widowed 4 □ Divorced Year or Dates injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) nd Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Stewarts Department Store Manager of Retail Sales 12 Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Milton Madison Richards Bessie Annette Waltz permit. Page 1 and 2 should Department of Health and M Important: If item 27 is mar any injury or other traumati 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3418 Mt. Carmel Road-Upperco, Maryland 21155 Gail Hale-daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Parkwood Cemetery 1 XBurial 2 Cremation 3 Removal from State Parkville, Maryland Feb.7,2011 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Evans Funeral Chapel and Cremation Services 21234 ME -ondrae 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Pregnant at time of death Month Day Year signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform 1 Yes 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: မ 1 🗌 Yes After this 1 Inpatient 2 I ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Natural 28c. Injury at 28d. Describe how injury occurred 5 Pending s after death.

I Director: A
ed in by the fu 1 Yes 2 🗌 No Investigation 6 Could not be Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Eertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated | Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FEB 0 8 2011 State Registrar

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Division of Vital Records, P.O. Box 68760

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Christopher Nathan Magalhaes	State of Maryland / Department of Health and Mental Hygiene	
1. For State	Cartificate of Dooth	

			1- For State Registrar	,,	Certifi	cate of	Death		F	Reg. No.	_		
Med	Physici dical Exami	an/	1. Decedent's Name (First, Midd		er Nathan Magalhaes					ath Day Year 30, 2011	3. Time of Death 1325 hrs		
			4a. Facility Name (if not institution 3 Wicklow Court	on, give street and number)	41	o. City, Town, o Waldorf	Location of Dea	ath	4c. County of Deal Charles	h			
	Funeral Director		5. Social Security Number 197-82-1490	Fore									
	Maryland 28a-f show any d at once.	or	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location  MD Charles Waldorf										
	the Maryl: ia or 28a-f	Director	10e. Street and Number 3 Wicklow Co	ourt	10f. Zip Code 20602			02		10g. Citizen of What Co United S			
2	ter death with ", or items 23 er must be no	Funeral	11. Marital Status 1 Never Married 2 N 3 Widowed 4 Div	arried 12. Was Decedent Armed Forces? 1 Yes 2 vorced If Yes, Give Year		If Yes	s, specify Cuba	spanic Origin? ( n, Mexican, Pue specify:	Specify Yes or N rto Rican, etc.)	White, etc.	rican Indian, Black,		
	Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygeine. Important: If item 27 is marked nther than "natural", or items 23a or 28a-f sho injury ar other traumatic event, the Medical Examiner must be notified at once.	Be Completed by	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)  Never Worked  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  Never Worked							/Industry			
	D 21215-0036 should be filed within 72 and Mental Hygiene. 7 is marked other than natic event, the Medical												
	MD 21 d 2 should I: th and Mer a 27 is mar iumatic eve	70	19a. Informant's Name/Relations Tiffany Maga	hip (Type, Print) lhaes/Moth	er	19b. Mailing 3 Wi	Address (Stre	et and Number of Court,	or Rural Route Nu Wald	mber, City or Town, State orf, MD 20	0602		
	Baltimore, learnit. Pages I and Department of Heal (mportant: If item injury an other tra		20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, Burial 2 X Cremation 3 Removal from State IVY Hill Crematory 5, 2011  20b. Place of Disposition (Name of cemetery, Tebruary 5, 2011  Philadelphia, PA										
		11	21. Signature of Funeral Service	e ENIAN	150	2EV 88	ans Fu	ineral ford R	Chapel d. Par	& Cremat: kville, Mi	ion Service 21234 Approximate Interval		
	Physician /Medical Examiner		23a Part I. Entur the disease, or failure. List only one cause immediate Cause (Final disease or condition resulting in death)		lic Ac			Dehydr	ation a	nd	Between Onset and Death		
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	b. Due to (or as a cons	equence of):		-						
	uted nd ransit	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a const									
	'60, cate be executed physician and he burial - transit	Medical	X UNPENDED	AMENDED 23	a,pt.Il	[,27 p	er me g	914 4-6	-ll vt				
	Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi-	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in topast 12 months?  1 Yes 2 No 9 Un	4 Pregnant at	Ectopic preg	gnancy	23d. Date of delive Month	ry Day Year					
	the de	Phy	Part II. Other significant condi	9 Unknown	h but not result	ting in the un	derlying cause	given in Part I.	23e. Did	tobacco use contribute t	the cause of death?		
	i, P.C ires that signed lbe deta	Completed by	Cerebral Pa	Lsy					1 Ye	es 2 No 3 Pro	obably 4 🗹 Unknown		
	ords w requi s been should	olete							24a. Was auto	psy prior to	utopsy findings available completion of cause of		
	Vital Records sysician: The law requi	E O							perf 1 <b>✓</b> Yes	ormed? death?			
	tal Recision: The certificate rector, page	å	25. Was case referred to medica examiner?	Hoopital:	0 = 50	/O. d= =4i==4		Other,		Residence 6 🗸 Oth	or: Saana		
	ing Physic After this uneral dir	<u>ا</u>	1 Yes 2 No 27. Manner of Death	28a. Date of Inju (Month, Day,	ıry 281	/Outpatient b. Time of Inj		ury at Work?		how injury occurred	Sr. deene		
	ttendin leath. tor: A	atior	1 X Natural 5 Pen 2 Accident Inve		cai)		1	Yes 2 No					
	Division of Vital Records, P.O. ital or Attending Physician: The law requires that thus after death.  Frai Director: After this certificate has been signed by lifed in by the funeral director, page 2 should be detaclined in by the funeral director, page 2 should be detaclined.	Certification:	3 Suicide 6 Could not be determined (Specify)  28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State)  28f. Location (Street and Number or Rural Ro or Town, State)										
	Division of V To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After it completely filled in by the funeral	Medical C		hysician: To the best of m miner:On the basis of exa and manner stated.									
	E ≯E 8	Me	29b. Signature and title of certifi		<i>W</i>		29c. Licen O.C	se number .M.E.		29d. Date signed (M January 31, 20			
-	8 V		30. Name and address of person Carol Allan, MD As	•	ed cause of death (Item 23a) dical Examiner 900 W. Baltimore Street, Baltimore, MD 21223						3		
	Si Regis	tate	31. Date filed (Month, Day, Year)	- 32. Revisite	k's Signature	la de	Part Company						

DHMH 17 Rev 1/2001 OCME 2006

OCME

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year Feb 3, 2011 5:45p.m.M Marion Delores Novak Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carroll Hospital Center Carroll Westminster 5. Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 F May 6, 1928 Country) Director 217.24.7402 82 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Carroll Sykesville 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 2108 Harvest Farm Road. 21784 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: White Yes Give 3X Widowed 4 ☐ Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Westinghouse Inventory Clerk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fi Department of Health and Mental Important: If item 27 is marked ပ Harry Sturgeon Mary A. Barbooka 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan Denker- Daughter 707 East Old Liberty Rd. Sykesville, MD 21784 Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) any injury or 1 Burial 2 X Cremation 3 Removal from State Atlantic Crematory 2/7/2011 Glen Bernie, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke 1630 Edmondson Ave. Catonsville, MD 21228 . Signature of Funeral Service Licenses MO1050 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Stag disease or condition resulting in death) nd Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) nding physician and use as the bunal-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Day Month Pregnant at time of death signed by the at d be detached for P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records. Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate 2 4 No 1 Yes ☐ Yes Division of Vital Funeral Director: After this certific sted filled in by the funeral director, 25. Was case referred to medical To Be 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 ☐ No 4 Nursing Home 5 Residence 6 other (Spec 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28b. Time of 28d. Describe how injury occurred To the Hospital or Attending 1 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signatur and title of certifier 29d. Date signed (Month. Dav. Year) D 52035 sel, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Westminster My 291 Stoner 21157 LITA CICO

DHMH 17 Rev 7/2009

Registrar

31. Date filed (Month, Day, Year)

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32, Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month A M HUMPHREY )GUDA 10 41 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** SINAI MOUPITAL BALTIMORE CITY DALTIMORE 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Jan. 28, 1967 Birthplace (State or Foreign Country) **Funeral** 6. Sex 7. Age (In yrs. last birthday) Hours Min. 1 🙀 M 2 🗆 F Director 084-80-5163 43 Kenya Usual Residence of Decedent show 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1XXYes 2 No NY New York New York 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral U.S.A. 17 Barrow Street 10014 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force þ 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 X No Specify. Completed 3 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) One if by Land Elementary/Seconday (0-12) College (1-4 or 5+) Two if by Sea Reservation Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Jonah Oguda Lily Nyathogora 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn Oguda (Sister) 120 Coliseum Ave., Apt. 312, Nashua, NH 03063 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State Date 🛚 Burial 2 🗆 Cremation 3 🗆 Removal from State Rosedale Cemetery 2-9-11 4 ☐ Donation 5 ☐ Other (Specify) Linden, NJ 21. Signature of Funeral Service Licensee Greenwich Village Funeral Home 22. Name and Address of Facility thiendard Tibles M01284 199 Bleecker St., New York, NY 10012 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ (ARDIOGENIC SHOCK disease or condition resulting in death) Medical Due to (or as a consequence of Examiner CARBIOMY OPATHY -LOIOPATMIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury that initiated experting the control of the cont Due to (or as a consequence of): Exam attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of doct IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnation 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 🔀 No Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined

State

within 24 hours a To the Funeral I

Medical

29a. Certifier (Check

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MF. RUBENTE

29b. Signature and title of certifier

Registrar

Registrar's Signatu

City or Town, State)

BALTIMONE,

29d. Date signed (Month. Day, Year)

MO 2120 B

25/2011

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D0027619

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

1838 Greene Tree Ro- #420

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death FOR Physician/ Day ADELE 9:45A M 201 Medical 4a. Facility Name (if not institution, give street and number, **Examiner** or Location of Death 4c. County of Death e of Birth **Funeral** If Under 1 If Under 9. Birthplace (State or Foreign 1 □ M 2 🗹 F Months Country) **Director** Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 🗹 Yes 2 🗌 No 10f. Zip Code 10g. Citizen of What C Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Bace - American Indian Black, White Be Completed by 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2 No Maryland 21215-0036 1 Yes 2 No and Mental Hygiene.
Is marked other than "natural", Specify 3 ₩Widowed 4 □ Divorced Year or Dates or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) nday (0-12) College (1-4 or 5+) 's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Surname မ 19a. Informant's ame/Relationship (Type, Health attem 27 Wilson Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 a
Department of I
Important: If ite
any injury or ot Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Lie Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. 23a. Part 1. Approximate Interval Between et and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Chronic Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Month 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Munknown Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director, After this certificate has completed filled in by the funeral director, page 2 s autopsy performed' 1 Yes 2 XNo 1 Yes 2 No To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital 1 Yes 2 **X**0No 4 Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 27. Manner of Deat 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Watural 5 Pending injury 1 🗌 Yes 2 🗆 No Acciden
Suicide Accident Investigation 6 Could not be . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) D 57088 Than foon, mi) 04,2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 301 ST. # 60 21202 Atimox, m) Cu 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ February 03, 06:30 Laverne Oswalt Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford 1606 Shirley Ave. Joppa Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 🛛 F Months Days Hours Min Aug. 14 86 432-30-2998 1924 Conway, Director Arkansas Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director Maryland Harford 1 🗆 Yes 2 🔀 No Joppa 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 1606 Shirley Ave. 21085-2516 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. d Mental Hygiene. marked other than "natural", or i 1 Never Married 2 Married Š 1 ☐ Yes 2 No Specify: Specify: White Completed 3 Widowed 4 X Divorced other traumatic event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Waitress Food Service 6 N/A Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 7 is marked of Albert L. Kersey Nellie Rodger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Monkton, Maryland 21111-1229 1307 Blue Mount Road Mr.Kenneth L.Oswalt (Son) item 20c. Location - City or Town State (Harford County) 20a. Method of Disposition 20b. Place of Disposition (Name of Fricay, Feb. 04, 2011 permit. Page 1 a Department of H Important: If ite any injury or ot cemetery crematory or other place)
Fyans Funeral Chapel and
Cremation Services, Inc. 1 🗆 Burial 2 🛛 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Forest Hill, Maryland Peaceful Alternatives Funeral & Cremation Cotr., P.A. 2325 York Road, Timonium, Maryland, 21093 21. Signature of Funeral Service Licensee Jeffrey L.Cair, Sr. Mir, s. Lic.#M00677 Approximate
Interval Between
Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Metastatic disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical that the death certificate be ending pure IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 month Month Dav Year Pregnant at time of death Unknown 1 ☐ Yes 2 ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 Yes 2 NO Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica after death.

Director: After this certific d in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \( \text{Nursing Home} \) 5 \( \text{M Residence} \) 6 \( \text{Other} \) Other (Specify) ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of Certificate: 28d. Describe how injury occurred Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Che Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only 29b. Signa 29c. License number 29d. Date signed (Month, Day, Year) D45390 February 374.2011 Name and andress of person who completed cause of death (Item 23a) (Type, Print)

NON D. COZ South Although Boad # 200, Bel Air

DHMH 17 Rev 7/2009

Registrar

filed (Month, Day, Year)

FEB 0 8 2011

Baltimore, Maryland 21215-0036

68760

Box

P.O.

Records,

Division of Vital

32. Registrar's Signature

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		For State	Plea	ase Type or State o			d / De	oartmer	nt of H	lealth and N			Legible.	03352	
Physicia Medic			Registrar  Certificate of Death  ecedent's Name (First, Middle, Last)  Krishna Reddy Ontaru								2. Date of De Month	Reg. No. eath eath 7, 2	2011 Year	3. Time of Death 6:20 A M	
Examin		4a. Facility Name <i>(if</i>			4b. Cíty,	Town, or	Location of Death Towson		4c. Coun		nty of Death <b>Baltimore</b>				
Funeral Director		5. Social Security No. <b>213-81-6</b>	6. Sex 1 X M 2 □ F	7. Age	e (In yrs. Ia <b>29</b>	ast <i>birthd</i> ay Yrs.	rthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.			8. Date of Bir (Month, Da <b>May</b>	th ay, Year) <b>3, 1981</b>		thplace (State or Foreign untry) <b>Nellore</b>		
yland •f show ed at	ctor	Usual Residence of Decedent  10a. State  10b. County  Howard				10c. City	10c. City, Town or Location  Ellicott City							10d. Inside City Limits	
n the Mar a or 28a be notifi	al Director	10e. Street and Nun						10f. Zij	o Code			10g. Citiz	en of What Co		
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	3114 Whea  11. Marital Status  1 Never Marri		12. Was Dece	rces?		3. 10	21043  13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)						rican Indian, e, etc.	
hours afte natural", o lical Exan	Completed b	3 Widowed	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates.						al Occup				pecify: 1311 d of Business	an Indian Industry	
within 72 giene. er than "i the Mec		Elementary/Second	-4 or 5	+)	life.	ive kind of work done during most of working e. DO NOT use retired)  Pro. Analyst / Software Engineer  Compu						Technology			
d be filed dental Hy irked oth tic event	To Be	17. Father's Name (i				18. Mother's Nam			-	h					
d 2 should alth and N 27 is ma er trauma		19a. Informant's Na Suneetha		hip (Type, Print) (a spouse								Ontaru Jayaramaiah  oute Number, City or Town, State, Zip Code)  cott City, MD 21043  e 20c. Location - City or Town, State  B, 2011 Parlin, NJ  Ellicott City, MD 21043  espiratory arrest, Approximate			
Page 1 an nent of He int: If iten iry or othe		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)					emetery, c	position (Nar ematory or c uneral Ho	other plac	e)	Date <b>08, 2011</b>	20c. Loc	•		
permit. Departri Importa any inju		21. Signature of Funeral Service Licensee  22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043													
hysician/		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between Onset and Death  Approximate Interval Between Onset and Death													
Medical Examiner		resulting in death)  Due to (or as a consequence of):													
uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events  c.													
a a e		resulting in death) Last  Due to (or as a consequence of):													
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Pureral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the bu	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown   No 12   Unknown   No 23c. If yes, outcome of pregnancy   1   Live Birth 2   Fetal death 3   Ectopic pregnancy   23d   Ectopic pregnancy   4   Pregnant at time of death   5   Other (specify)   9   Unknown									3d. Date of del	Date of delivery Month Day Year			
ires that the signed by detaction	þ	1) .	icant condition	Euclo			_	underlying	cause giv	en in Part I.	23e. Did t			the cause of death?	
he law requite has beer age 2 shou	Completed		7									psy ormed?	prior to death?	topsy findings available completion of cause of	
s certifica director, p	To Be C	25. Was case referred examiner?	Hospital:	FR/Outpat	ient 3 □ D	Othe	ace of Death (Chec	k only one)							
nding Phy tth. : After thi e funeral o		27. Manner of Death  1 Natural 2 Accident	5 Pendir	of injur th, Day	у	28b. Time injury	of 28c. Injury at 28d. Describe how injury occurred					- Proper			
al or Atte s after deg I Director d in by th	Certificate:	3 ☐ Suicide 4 ☐ Homicide	6 Could determ	ined 28e. Place	28e. Place of Injury - At home, farm, street, factory, office 28f. Local						28f. Location (S City or Tov		Number or Rui	ral Route Number,	
ne Hospit: in 24 hour: ne Funera pleted fille	Medical	29a. Certifier 1 (Check 2 only one) 3	Medical E	Physician: To the be Examiner: On the bas Nurse Practioner:	is of ex	amination	and/or inv	estigation, in	my opinic	n, death occurred a	t the time, date a	and place, a	and due to the	cause(s) and manner stated.	
vithi Com		29b. Signature and t	ti le of certifier	Q.M -					DO	number 71287		29d. Date	signed (Month	ı, Day, Year)	
5 v		30. Name and address	s of person	who completed caus		eath (Item	23a) (Type				5,B	altin	uo>e	Hogigan	
Stat Registra		31. Date filed (Month			<del></del>	r's Signat	ure								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month RICHARD SPENCER 10:43M PUMPHREY Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner womaro HOWARD COUNTY GONGRA Counsia HUSPITM 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea March 14, Social Security Number **Funeral** 9. Birthplace (State or Foreign 1 💢 M 2 🗆 F Country) Marvland Director 76 578-42-1053 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Sykesville Maryland Carroll 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral **USA** 2**1**784 4 Bethway Drive Apt.104 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ☐ Never Married 2 🎇 Married Completed by 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White and Mental Hygiene.
is marked other than "natural", 3 Divorced Specify: Year or Dates or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 12College (1-4 or 5+) Transportation Truck Driver Be Page 1 and 2 should be filed ment of Health and Mental Hy ant: If item 27 is marked oth 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည William Pumphrey Unk. Kern 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mandy Pumphrey, Wife Bethway Drive Apt. 104 Sykesville, Maryland 21784 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 a
Department of IImportant: If ite
any injury or ot 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place, Metro Crematory Inc. 02/08/11 Baltimore, Maryland Signature of Funeral Service Licensee Thomas Gregor Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 homa 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Lorges Onset and Death Immediate Cause (Final Physician/ ACUTE STRUKE LEFT REMETER AM PARVETAZ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner STENDUS RIGHT CARETIO 14000 MUTOR Y Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examir sician and burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last PORIPHERM ARTAMAL VASUUAR DISEASE OVER 10 YOAR Due to (or as a consequence of): Physician/Medical the anding p IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ atten for u in the past 12 months?

1 Yes 2 No Month Day Year 9 Unknown signed by the Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ⋧ MORTONSIM Records, 1 Yes 2 No 3 Tobably 4 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 2 110 2 -10 within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 400 Other: 1 Description 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No ☐ Accident ☐ Suicide Investigation 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Cartifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 036974 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) O. NYANITOM MO 10710 CHARTER DR #30, COLUMBIA MO

Registrar DHMH 17 Rev 7/2009

State

DAVIO

31. Date filed (Month, Day, Year)

0 8 2011

Box 68760

P.O.

of Vital

Division

arke

32. Registrar's Signature

21544

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 6:32P.M Physician 24 2011 January Yvonne Preston /Medical Michelle 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE AGNES HOSPITAI If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. 1 ☐ M 2 💢 F Yrs. MD 09 08 48 62 Director 218-48-1349 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County "natural", or items 23a or 28a-f show 1 TXYes 2 □ No Director Baltimore NA MD 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21229 4411 Pen Lucy Road Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Pages 1 and 2 should be filed within 72 hours after of ment of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or iten ury or other traumatic event, the Mexical Experience. 1X Never Married 2 ☐ Married 1 ☐ Yes 2 X No Baltimore, Maryland 21215-0036 Specify: Black Specify: 2 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Private Duty Nursing Assistant lyr 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ella Murphy ပ Charles Preston 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 Is any injury or other trau Baltimore, Md Crest Heights Road, 4159 Cherly Preston-Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King Memorial Park 2/3/2011 Woodlawn, Md 22. Name and Address of Facility
March F/H West
4300 Wabash Ave, 21. Signature of Funeral Service Licensee Md 21215 Baltimore, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediat 1 Cause (Final disease or condition) Approximate Interval Between Onset and Death a Coronary Arteriscleratio Vasular Vaknown **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the buriat-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Dav in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 9 Unknown 9 Unknown After this certificate has been signed by funeral director, page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2/ No 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1∐Yes 2☑No 2 ER/Outpatient 3 □ DOA 1 🔲 Inpatient Certification: To within 24 hours after death.

To the Funeral Director: After this 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 00055849

Registrar DHMH 17 Rev 1/2001

State

Preston, Michelle

900 Caton Avenue Baltimore Marylant

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Anes Ho

Berge

FEB 0 8 2011

Year)

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) February 2011 5:30 Ам **Physician** /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A Baltimore Overlea Health & Rehabilitation | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Fore Months Days Hours Min. | Min. | March 25,1918 | Baltimore, MD 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 💢 F 220-05-8298 92 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Expreminer must be notified at once. N/A 1 XYes 2 □ No MD Baltimore Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21239 1651 East Belvedere Avenue Apt. 330 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: White Specify: <u>Ş</u> 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Miller Music Elementary/Secondary (0-12) College (1-4or 5+) Store Manager 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Gordon Bennett Mamie Eckels ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3812 Schroeder Avenue, Perry Hall, MD 21128 Paul Powell, Jr./ Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Februarv 1 N Burial 2 □ Cremation 3 □ Removal from State Parkville, MD Parkwood Cemetery 04, 2011 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Evans Funeral Chapel & Cremation Services 8800 Harford Rd. Parkville, MD 21234 allyuitin the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or each line 23a. Falt 1. Enter the disease, or complications the ock, or he in failure. List only one caus-Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine the Hospital or Attending Physician; The law requires that the death certificate be executed Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month ☐ Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, <u>δ</u> 1 L Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an perform performedy 1 ☐ Yes 2 ANo 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 1 Matural 2 Accident 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at/ Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: 6 □Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and marine as season.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Registrar

State

31. Date filed (Month, Day,

EB 08 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Raven Brud, Baltimore
M. KHAN 5601-Lock Raven Brud, Baltimore

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 6:30 A M February 2011 George James Phebus Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Timonium Stella Maris Hospice Maryland 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 220-12-9700 Months Days Hours July 13, 1926 Maryland 84 Director Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director notified Baltimore Nottingham MD 28a-f 1 🗆 Yes 2 🛣 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be I Funeral 21236 4240 Klein Avenue USA death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces <u>></u> 1 Never Married 2 Married XYes 2 ☐ No Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Specify: white If Yes, Give Completed 3 ₩ Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Fastern Stainless Steel Worker Elementary/Seconday (0-12) College (1-4 or 5+) Steel Company 8 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ဂ Alice Cox George T. Phebus 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3622 Robin Air Court-Pasadena, Maryland 21122 Polly Harding-daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Moreland Menorial Park 1 X Burial 2 Cremation 3 Removal from State Feb.4,2011 Parkville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) permit. 21. Signature of Funeral Service Licensee 22 Name and Address of Ficility hapel and Cremation Services 8800 Harford Road-Parkville, Maryland 21234 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) SEPSIS Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury) Examine Due to (or as a consequence of) To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day Pregnant at time of death 5 Other (specify) g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 00 3 Probably 4 Unknown 1 Tes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy Hospital or Attending Physician: 724 hours after death.
Funeral Director: After this certifics **Division of Vital** Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: ဂ္ 1 🔲 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Specify) HOSPICE 28c. Injury at work?
1 \square Yes 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred X Natural injury 5 Pending 2 🗌 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ☐ Homicide determined City or Town, State) n 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the within To the 29d. Date signed (Month, Day, Year) 2011 erson who completed cause of death (Item 23a) (Type, Print) JACKIE JONES, **CRNP** 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 08 Registrar

FEBRUARY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death February Physician/ 2011a 1806 Larry Nathan Pharr Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Washington Adventist Hospital Takoma Park 8. Date of Birth (Month, Day, Year) Sep 9, 1951 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number **Funeral** Hours 1X M 2 Washington, DC Director 578-70-2650 59 Usual Residence of Decedent or 28a-f show notified at death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No Maryland Montgomery Takoma Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò ral", or items 23a o Examiner must be Funeral 7600 Maple Avenue #1202 20912 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status rmed Forces? Black, White, etc. 1 Never Married 2 XMarried þ Baltimore, Maryland 21215-0036 iled within 72 hours after If Yes, Give Year or Dates. 1976–80 1 ☐ Yes 2 X No Specify. Specify: African—American "natural", Completed 3 Widowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Ith and Mental Hygiene. 27 is marked other than r traumatic event, the M Elementary/Seconday (0-12) College (1-4 or 5+) Electronics Technician University Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t. Page 1 and 2 should be file tment of Health and Mental rtant: If item 27 is marked of njury or other traumatic evi ပ Vardrey Christopher Pharr Jannette Mayzie Miller 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7600 Maple Avenue #1202 Takoma Park, Maryland 20912 Catherine V. Pharr/wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1
Department of I
Important: If it
any injury or of cemetery, crematory or other place 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 2/9/ 2011 Woodbine, Maryland lure of Funeral Service L Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 M00957 Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ e1051 disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Live Birth 2 Fetal death Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed? death? this certificate ! 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) the funeral director. examiner? Hospital Other: 2 No 1 Tes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After 5 Pending (Month, Day, Year) 1-Natural injury To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Afte completed filled in by the fun М 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 📈 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 19Koma 160( arroll 31. Date filed (Month, Day, Year) FEB 0 8 2011 32. Registrar's Sign State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 0926AM Februari Medical 4a. Facility Name (if not institution, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Battimore Raitimore If Under 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Funeral 1 ■ M 2 □ F Hours Country) Director rainia permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c, City, Town or Location Funeral Director 1 1 Yes 2 ☐ No more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates Specify. 3 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College 4-4 or 5+) Elementary/Seconday (0-12) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Şurname) ဂ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) to Doreen 20a. Method of Disposition
1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 4 Donation 5 Other (Specify) 21. Signatur of Funeral Service Licenses 22. Name and Address of Home, P. A. B0-NOC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition SISTAGE Medical resulting in death) Due to (or as a consequence of): Examiner leoboligu Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examiner attending physician and Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d, Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Year Month Dav 9 Unknown been signed by should be detack Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 ☐ No 3 ☑ Probably 4 ☐ Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an **Director:** After this certificate has I autopsy performed 1 ☐ Yes 2 ☐ No 2 No 25, Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 🗆 No ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5  $\square$  Pending ✓ Natural 1 Yes 2 No Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ☐ Homicide within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) equalor 2011 Tebruery 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FEB 0 8 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

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Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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death ctor: /y the .y	Certificate:	2 Accident 3 Suicide 4 Homicide	Investigati 6 Could not determine	be 280 Blood of Inju					28f. Location (Street and Number or Rural Route Number,				
al or / s after al Dire		4 🖂 Horricide	determine	building, etc							Town, State)		
Hospit 4 hour Funera ed fills	Medical	29a. Certifier 1 (Check 2	Certifying Ph	nysician: To the best of miner: On the basis of e	my knowle	dge, deat	h occured at the time,	, date and place, ar	nd due to the cau	use(s) and	manner as sta	ited. cause(s) and manner stated.	
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. We have successed as a fear death of the completed filled in by the funeral director. After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the bu	Me	only one) 3		urse Practioner: To the				e time, date and plac	ce, and due to the	e cause(s)		stated.	
દ્ય≮≈≖				sittus						02/		O[]	
		30. Name and adde	s of person who	Sulf UD  Completed cause of d  AVE SULT	leath (Item 2	23a) (Type	Print)	<i>5 1 ~ .</i>	210 : 6	-/	1		
οV				AVE 8017	r 20:	3 1	SALTIHOR	I, MD 2	41209				
Stat		31. Date filed (Month	1, Day, Year)	32. Registra	ar's Signatu								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death HIOAM Physician/ Month Rew Doris Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner Bel Air Health and Rehabilitation lente Bel Hartor 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign Funeral Jan 12, 1 🗆 M 2 🖵 F Hours Year 920 Mary Tand 91 Director 217-09-7808 Usual Residence of Decedent 28a-f show r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director Harford Bel Air 1 Yes 2 No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral 1817 Kalmia Road 21015 U.S.A 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Completed by ☐ Yes 2X No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXXNo Specify: 3 ₩ Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Hairdresser Beauty permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Ward Brewer Virginia Victoria Schooler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16515 Frederick Rd., Mt. Airy, MD Carol Agrawal-daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Gardens of Faith 2/4/11 Overlea, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Censee William G. Dau 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd., Towson. MD 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ ay disease or condition Medical resulting in death) onsequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) eral Director: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2 No
9 Unknown Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Rew 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical To Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🔲 Yes 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending 1 🗌 Yes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined the Hospital Medical 1 Lertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State

31. Date filed (Month, Day, Year) FEB 0 8 2011

KHUSWA

29b. Signature and title of certifier

32. Registrar's Signature wark.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

615

Registrar

W. MACPHAIL RD #106,

29c. License number

D56545

BELAIR MD 21014

29d. Date signed (Month, Day, Year)

2/2/11

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Physician/ Day Koar Rley -15 AM 02 04 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Heritage Baltimore Center Dundalk, MD 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) West Virginia 6. Sex 8. Date of Birth **Funeral** 7. Age (In yrs. last birthday) Month, Day, 1 □ M 2 🙀 F Days Min. 74 233-58-8500 1936 Director Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Dunda1k MD 1 Yes 2 No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 15 Wells Avenue 21222 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 0 1 X Never Married 2 Married Completed by ☐ Yes 2 🛣 No Yes, Give should be filed within 72 hours after and Mental Hygiene. Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. 3 🗆 Widowed 4 🗆 Divorced Specify: White Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Waitress Restaurant 9 Years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Willie Hughes Perry Roark 1 and 2 should be of Health and Me item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15 Wells Avenue Dundalk, Maryland 21222 Emma E. Braun (Sister) 20b. Place of Disposition (Name of cemetery, crematory or other place)
Holly Hill Mem. Gdns. 2/8/2011 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 and Department of Hamportant: If ite any injury or ot 1 

■ Burial 2 

□ Cremation 3 

□ Removal from State Middle River, MD 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses <sup>22</sup>Durankurk Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 239 art 1. Enter the disease complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure ast only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. CHRONIC GOSTRUCTIVE PUHCNARY DISEASE PURCHARY DIS Approximate Interval Between Onset and Death Physician/ Medical Due to (or as a consequence of): **Examiner** ears Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that introduced to the control of To the Hospital or Attending Physician. The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending housenand. Exam attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Records, 1 Yes 2 No 3 Probably 4 Vunknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 N 2 🗌 No 1 🗌 Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending hours after death.
uneral Director: Aft 1 🗌 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) R 131555

61

State Registrar

nth Day 2011

Karen

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KOTEN J SRCKA 6095 Marshaler DR EIKRIDGE, HD 21075 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/  $P_M$ Mary Alice Rohman February Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Upper Chesapeake Medical Center Bel Air Harford If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Davs Hours Min Sept. 13, 68 1942 Director 220-40-1710 Maryland Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Harford Pylesville 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3086 Whiteford Road 21132 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 No If Yes, Give 1 Never Married 2 Married Completed by Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic puomt the 18. College (1-4 or 5+) Elementary/Seconday (0-12) Secretary At Aberdeen Proving Ground Covernment Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Franklin O'Neil Johnson, Sr. Edith Gabler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Timothy C. Rohman (Spouse) 3086 Whiteford Road, Pylesville, Maryland 21132 Baltimore, 20a. Method of Disposition
1 ☐ Burial 2 🕏 Cremation 3 ☐ Removal from State 20c. Location - City or Town, State 20b. Place of Disposition (Name of Evans Funeral Chapel Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2011 21. Signature of Funeral Service Licensee Jeffrey R. 22. Name and Address of Facility Exams Funeral Chaptel & Cremation Services — Bel Air 3 Newport Drive, Forest Hill, Maryland 21050 Testerman (M01543) Testimo 23a. P 11. E fee the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or b art failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 1 DIOPATHIC Physician/ disease or condition resulting in death) MOTEHS Medical Due to (or as a consequence of) Examiner عاد Equentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. attending physician and for use as the burial-trar that initiated events Due to (or as a consequence of): 600 303 resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy In the past 12 months?

1 Yes 2. No Pregnant at time of death 5 Other (specify) 4 ☐ Pregnant : g ☐ Unknown 1 ☐ Yes 2.2 9 ☐ Unknown P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. is certificate has been signed i director, page 2 should be det 23e. Did tobacco use contribute to the cause of death? Completed by OBESITO Division of Vital Records, 1 ☐ Yes 2 ♥No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 1 ☐ Yes 2 No Be 25. Was case referred to medica 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ၉ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural work? 1 🗆 Yes 2 🗆 No 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after de To the Funeral Directo completed filled in by t 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State

31. Date filed (Month, Day

D66342

BEL-AR

2/4/11

MO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CHESA

32, Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 5<sup>Day</sup>2011 February 6, Physician/ EDWARD SALKIN 7:00 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1302 Pontiac Avenue Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours 1 **X** M 2 □ F July 25, 1940 185-32-0782 Pennsylvania **Director** 70 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at should be filed within 72 hours after death with the Maryland and Mental Hygiene.

is marked other than "natural", or items 23a or 28a-f sho. 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Director Baltimore N/A Maryland 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1302 Pontiac Avenue 21225 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🗶 No If Yes, Give Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify White 3 Widowed 4 Divorced Year or Dates Page 1 and 2 should be filed within 72 hours ment of Health and Mental Hygiene. ant; If item 27 is marked other than "natur ury or other traumatic event, the Medical I ury or other traumatic event, the Medical I 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Transportation Truck Driver Be 17. Father's Name (First, Middle, Last 18. Mother's Name (First, Middle, Malden Surname) ၉ Gertrude Salkowitz Salkin Samue1 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth M. Salkin (Wife) 1302 Pontiac Avenue, Baltimore, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 2/8/2011 Glen Burnie, Maryland Important; If any injury or Atlantic Crematory, LLC 4 Donation 5 Other (Specify) 21. Signature of Funeyal Service Licensee Kevin E Ecker 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 237 E. Patapsco Avenue, Baltimore, Maryland 21225-1856 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Kenal Caucer Physician/ disease or condition resulting in death) Kecurren Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine it any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of is certificate has been signed by the attending physician and director, page 2 should be detached for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the burn Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) 2 No 4 ☐ Pregnam 9 ☐ Unknown 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Melletus 2 No 3 Probably W Unknown Heart Failure Congestive 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? HyperTenzion perform 1 🗌 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 KResidence 6 Other (Specify) 2 No ၉ 1 Inpatient 2 I ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural work? 5 Pending 1 ☐ Yes 2 ☐ No Investigation ☐ Accider
☐ Suicide Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical Zertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

KiAmbalavanar

31. Date filed (Month, Day, Year)

08

FEB

DHMH 17 Rev 7/2009

Oakwood

7845

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month рΜ 2011 9:45 February CHARLES ROGER SIGAFOOSE Medical 4a. Facility Name (if not institution, give street and number)
SUMMIT PARK NURSING HO Examiner 4b. City, Town, or Location of Death 4c. County of Death NURSING HOME Catonsville Baltimore Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F Months Days Hours April Day Maryland 88 Director 214-12-0593 Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland 1335 Cambria Street N/A 1 K Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21225 **Baltimore** USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☒ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: If Yes, Give White 3 X Widowed 4 Divorced WW 2 Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) 12 College (1-4 or 5+) Seagrams Distillery Instrument Technician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edward Roger Sigafoose 2 Margaret Elizabeth Dagenhardt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Beth Wire (Daughter) 535 Forest Lane, Catonsville, Maryland 21228 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Cedar Hill Cemetery 1 X Burial 2 Cremation 3 Removal from State 2/7/2011 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Kevin E Ecker 22. Name and Address of Facility McCully-Folyniak Funeral Home, P.A. 237 E. Patapsco Avenue, Baltimore, Maryland 21225-1856 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. CARDIOM YO PATITY Onset and Death Immediate Cause (Final (CHEMIC Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner monne Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or linjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): YPERTENSION Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Month Dav Year Pregnant at time of death Yes 2 No sate has been signed by the spage 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an prior to completion death? performed? MA hours after death.

uneral Director: After this certificate 1 Tes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at 1 Natural 5 Pending work?
1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year, 10056948 ATTENDING February 4, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

James Tansinda M.D. 3455 Wilkens Avenue, Baltimore, Maryland 2/929

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

FEB 0 8 2011

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Lucille Anne Summers 2011 7:50p. January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner Baltimore** 22 Gwynn Lake Drive Baltimore If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Year) 1936 July 23, 1 □ M 2 🛣 Months Days Hours Min 74 218-36-0691 Yrs. **Director** Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hyglene. Butt if ifem 27 is marked other than "natural", or items 23a or 28a-f shoury or other traumatic event, the Medical Examiner must be notified at uny or other traumatic event, the Medical Examiner must be notified at 10a, State Director 1 Yes 2 No MD Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 21207 USA 22 Gwynn Lake Drive 12. Was Decedent Ever in U.S. Armed Forces 2 1 ☐ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 of If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White Completed 3 X Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Domestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Virginia မ James Thurman Smith Ida Walker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Suzanne Jones - Daughter 7407 Spout Hill Road, Sykesville, MD 21784 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of IImportant: If ite
any injury or ot 1 🔀 Burial 2 🗌 Cremation 3 🔲 Removal from State 01/14/2011 Woodlawn Cemetery Woodlawn, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Haight Funeral Home & Chapel, PA 21. Signature of Funeral Service Licensee Brian L. Haight M00764 P.O. Box 195, Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Chronic Kidney Disease Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Diabetes Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Hypertension Cause (Disease or iinjury that initiated events resulting in death) Last burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Day Year g Unknown g 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 **X** No 1 Yes 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) Other: 2**X** No 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 24 hours after death Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical 🕱 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I 29b. Signature and title of certification 29c, License number D-4677130. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Marc E. Wilson, MD,4538 Edmondson Avenue, Baltimore, MD 21229 31. Date filed (Month, Day, Year) FEB 0 8 2011 32. Registrar's Signature Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician/ Salfner 7:10P M Shirley Fehruam Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Baltimore Randallstown Season's Hospice 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8, Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. Fe.b. 8, 1925 Maryland 219-16-8425 85 **Director** Usual Residence of Decedent 10b. County 10d. Inside City Limits 10a. State 10c. City. Town or Location death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at Director 1 ☐ Yes 2 🏝 No Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21207 USA Funeral 1925 Featherbed Lane Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces?
1 ☐ Yes 2 ☐ No Black, White, etc þ 1 Never Married 2 Married within 72 hours after Baltimore, Maryland 21215-0036 Specify: White If Yes, Give Year or Dates 1 Yes 2 X No Specify: "natural" Completed 3 XWidowed 4 ☐ Divorced the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 8 Meat Wrapper Grocery Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Gay L. Reeder John W. Smoot 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1395 Peace Drive; Pasadena, MD 21122 19a. Informant's Name/Relationship (Type, Print) Pamela Sutton 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🙀 Burial 2 ☐ Cremation 3 ☐ Removal from State 2/8/2011 Sykesville, MD Lake View Mem. Park 4 ☐ Donation 5 ☐ Other (Specify) Sterling Ashton Schwab Witzke 22. Name and Address of Facility Sterling Ashton Sc Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville 21. Signature Funeral Servi 23a. Part 1. Enter the dis ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final End. Stage Vascular Dementia Physician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner n any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and sted filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d Date of delivery in the past 12 months?
1 Yes 2 No Month Year Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed! 1 ☐ Yes 2 ☐ No Be ( 25. Was case referred to medical 26. Place of Death (Check only one) 4 □ Nursing Home 5 □ Residence 6 ☐ Other Specify examiner? Hospital 1 ☐ Yes 2 ☐ No Other: မ ER/Outpatient 3 DOA 1 🗌 Inpatient 2 🗌 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pending Accident 1 Yes 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital of within 24 hours a To the Funeral D Medical 29a. Certifier 🖳 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deadle occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number ns Riyapahre M.D DO057465 30. Name and address of person who completed cause of death (item 23a) (Type, Print)

NI EREPAKE M.D. 28355 MIDN AV-5-203

Registrar DHMH 17 Rev 7/2009

State

32. Registrar's Signature

N. S. Kajapake, M.D.

31. Date filed (Month, Day, Year)

FEB 0 8 2011

Baltimore, MD. 21209

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND ITEM#&,8,perFH,G912,2/14/2011,WS State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 300 A M DWain 20 Medical Facility Name (if not institution, give street and number) c. County of Death or Location of Death **Examiner** City, Town, 130 timere tal a timore Sex Age (In yrs. last bjrthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7-4-1927 9. Birthplace (State or Foreign Funeral Day, Years Months Hours Min. Country) 382 Director Usual Residence of Decedent 10a. State 10b. County 100- City, Town or Location 10d. Inside City Limits notified at Director · 28a-f 1 Yes 2 No timor eisters Town 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò Page 1 and 2 should be filed within 72 hours after death with the riment of Health and Mential Hygiene.

The strict of 15 is marked other than "natural", or items 23a or live to rother traumatic event, the Medical Examiner must be. I try or other traumatic event, the Medical Examiner must be. Funeral 71134 15A 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12, Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 ☑ No Black, White, etc. ģ 1 Never Married 2 Married 21215-0036 1 Yes 2 No Specify: If Yes, Give 3 ☑ Widowed 4 ☐ Divorced Completed Year or Dates aC 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Kind of Business Indust Cit Elementary/Seconday (0-12) College (1-4 or 5+) Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname ပ 19a. Informant's Name/Relationship, (Type, Print) 19b. Mailing Address (Street and Number City or Town, State, Zip Code) permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr MD 31238 20b. Place of Disposition (Name of certetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) カノナレら -10 <del>2</del>011 Signature of Funeral Service Licen 22. Name and Address of Facilit Funeral Services au mD21133 andali 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Que to (or as a consequence of) mon Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician d be detached for use as the burial Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 9 No Month Day Year Pregnant at time of death 9 Unknown 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Be Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy 2 🗌 No Yes 1 Yes completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: ျ 1 ☐ Yes 2 ☐ No Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Natural Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred hin 24 hours after death. the Funeral Director: After 5 Pending work? 2 No M Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie 2 [ 3 [ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) within 7 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 000 2011 05 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MERA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 08 FEB Registrar

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To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2:	edical	29a. Certifier (Check only one)  29a Certifier (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)  (Check only one)								
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1+1,		30. Name and address of person, who completed cause of	of death (Item 23a) (Type,	Print) 8817 4	15 1 17.02	Woods Room				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 1140PM Month MARCella Mae Saunders 5 m nuary 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Randalltown Baltimore 4017 WinLee If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗹 F (Month, Day, Year, 212-20-021 85 Director Usual Residence of Decedent Show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Director 1 Yes 2 No Baltimore andolltown Md 10e. Street and Number 10g. Citizen of What Country? Funeral WinLee USA 21133 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, þ 1 Never Married 2 Married 1 Yes If Yes, Give 3altimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: BLack 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည +15her UKN 19a. Informant's Name/Relationship (Type, Print) Son) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Randolltown Road Hande GREGORY 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method o Disposition 20c. Location - City or Town, State any injury or conce, 1 Burial 2 Cremation 3 Removal from State Woodlown, NoodLawn Cometery 2 -4-2011 5 Other (Specify) 21. Signature Fun 13 rvi e Lice see 22. Name and Address of Jacility Miller 3 Metropolitum Chapte Bacto. Md. 23a. Part 1. Enter the disease, or o mplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate ly one cause on each line. Immediate Cause (Final Physician/ Metastatic Coluh cahcer disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner Due to (or as a consequence of) if any, leading to immediate Cause (Disease or iinjury the burial-transi that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? Month Vear Day 2 No 1 ☐ Yes ∠ ☐ 9 ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Tes 2 No the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director, After t
completed filled in by the funera Natural 5 Pending 1 Yes 2 No Investigation 6 Could not be Accident Suicide
Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🗜 🗮 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) m. D. 5552 anos 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Owings Mills, Md. 21117 04, +2 m. D. 23 (rossroads Dr.

State Registrar 31. Date filed (Month, Day, Year)

FEB

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death STARLEPER FEBRUARY 03 2011 Physician/ 3:44pm M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death HARFORD FOREST HILL HEALTH AND REHABILITATION FOREST HILL If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8 Date of Birth 9. Birthplace (State or Foreign Funeral 1 🗆 M 2 💢 F Mattern 2ay, 19934 Mary Yand Director 215-30-1832 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 X No Harford Forest Hill Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21050 109 Forest Valley Drive USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force permit. Page 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examin once. Completed by 1 Never Married 2 Married 1 Yes Baltimore, Maryland 21215-0036 2 x No 1 Yes 2 x No Specify: White 3 ₩Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ဂ္ Evelyn Pearl Davis James Luther Rosser 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3203 Seiter Lane, Jarrettsville, Maryland 21084 Charles Edward Starleper Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2/7/2011 Lorraine Park Cemetery Woodlawn, Maryland 21. Signature of Funeral Service Lice Burgee Henss Seitz Funeral Home, Inc. 3631 Falls Road, Baltimore, Maryland 23a. Part 1. Exper the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Due to (or as a consequence of) demente disease or condition / Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) Due to (or as a consequence of) resulting in death) Last Physician/Medical The law requires that the death certificate be the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Pregnant at time of death 9 Unknown Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy page 1 Yes 2 No Yes 25. Was case referred to medical funeral director. Be 26. Place of Death (Check only one) examiner? 2 No Hospital: 1 Tes ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred To the Hospital or Attending Natural 5 Pending injury work? within 24 hours after death.

To the Funeral Director: Af 2 Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier 🕏 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Dal 30 032299

Registrar DHMH 17 Rev 7/2009

State

Box 68760

Records, P.O.

Division of Vital

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

DR. DAVID DUNN- 615 MACPHAIL ROAD- BEL AIR ,MD 21014

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 304M >1mmone February Medical 4a. Facility Name (Innot institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Manor Care Ruxton Towson 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Year) 1<u>926</u> (Month, Day, ) 1 🛛 M 2 🗆 F Months Days Hours Min. Country) Maryland Director 216-20-4575 84 June Usual Residence of Decedent 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location notified at Director 28a-f 1 Yes 2 No Baltimore Maryland Sparks 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number ms 23a or must be r Funeral 21152 62 English Run Circle Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 X Married ö Saltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: "natural" 3 Widowed 4 Divorced Completed White Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the 12 04 Insurance Agent Insurance of Health and Mental Hygie fitem 27 is marked other r other traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Helen Hohn Spangler | Simmons 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 62 English Run Circle, Sparks, Maryland Richard B. Simmons/Son 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State to <u>∓</u> 1 Burial 2 X Cremation 3 Removal from State Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 2/12/11 Glen Burnie, Maryland 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley Inc.
10 W. Padonia Road, Timonium, MD 21093 23a. Part 1. Enter the lisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Couse (Final disease or course) Physician/ disease or co resulting in death) + avance Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Year Day □ Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? To Be Completed by Insulin dependent 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Pertension has perform 2 No Yes 2 No 1 Tyes **Division of Vital** To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 🗘 No 1 Tes 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 Yes 2 No Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital or within 24 hours at To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier ss of person who completed cause of death (Item 23a) (Type, Print) Bellong Lane

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
 Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2011 Sterling Anthony Smith Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death County of Deat ANNET WASHINGTON MEDICAL BAUTIMERS GHEN MIF Age (In yrs. last birthday) If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1**X** M 2 □ F Months Days Hours Min. 01/07 **Director** 59 Maryland 214-54-6074 1952 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10d. Inside City Limits Director 10c. City. Town or Location 1 

Yes 2 □ No MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3220 Milford Ave. 21207 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Completed 3 Widowed 4 Divorced Black Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th Grade utility Supervisor Washington Metro Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Grafton Smith Sr Mary V. Darby 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tiffany Smith(daughter) 3220 Milford Ave., Baltimore, MD 21216 20a. Method of Disposition 20b. Place of Disposition (Name of 20c, Location - City or Town, State Date cemetery, crematory or other place) 1 🛣 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) King Mem. Park 02/12/11 Baltimore, MD of Funeral Service Lice <sup>22</sup>Joseph H. Brown Jr. 2140 N. Fulton Ave., 21. Sign 3 Funeral Home PA Baltimore, MD21217 sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a, Part 1, Enter the di shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death rot A Physician/ Acure disease or condition resulting in death) Medical Due to (or as a consequenc Examiner Esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury signed by the attending physician and deetached for use as the burial-transit 4RIDIAC Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 \( \subseteq \text{ Yes} \quad 2 \subseteq \text{ No} \) 4 ☐ Pregnant at time of death 9 ☐ Unknown Month Day Year 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown been Were autopsy findings available prior to completion of cause of death? 24a Was an cate has b page 2 sl autopsy within 24 hours after death.

To the Funeral Director: After this certificate h completed filled in by the funeral director; page performed 2 🗌 No 2 [ 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Yes Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manne of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? Accident Investigation 6 Could not be Suicide . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗀 only one 29b. Signature and title of certifi 29c. License number e and address of person who completed cause of death (Item 23a) (Type, Print) ilen Burne MD HOO 01 octal 32. Registrar's State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 30 per dvr c912 2-8-11 vt. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Year **Physician** 12:40AM HA2E 20 4a. Facility Nagne (If not institution, give street and number)

DENESS PAIK Way Center /Medical Town, or Location of Death 4c. County of Death Examiner Itamore If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign **Funeral** 1 □ M 2 🗹 F Months Days Min 220-32-2930 Usual Residence of Decedent Yrs. Director Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or items 23a or 28a-f show 0a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Michael Examiners, ust be notified at 1 Pres 2 □ No Director ltimor 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? entworth by Funeral 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗹 No 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry opard College (1-4or 5+) Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden, Surname) Be C0-11 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Earline Department of Health Important: If Item 27 any Injury or other tr 1020 Eve Baltz 3ham 21212 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State mount Cremoster 5 ☐ Other (Specify) Baltimore 4 ☐ Donation 21. Signature of Funeral Service Licenses Fineral Home, P 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed RHEUMATOID ARTHRITIS the burial-tran Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) s been signed by the same should be detached 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy performed? Yes 2 No certificate +001 ANGRENE 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To this within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral or 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 🗖 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or within 24 hours af To the Funeral D 29a Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

P.O. Box 68760.

Division of Vital Records,

DHMH 17 Rev 1/2001

MD

29c. License number

29d. Date signed (Month, Day, Year,

821 N. Eutaw St. Suite 308

0

2011

21201

Balto. Md.

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Sonberg 10:08PM **Physician** Charles rebruary 03 2011 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner The Johns Hopkins Hospital **Baltimore City** If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days Hours 1 **X**M 2 □ F 74 Director 216-30-7780 1936 Maryland Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 28a-f show 1 ☐ Yes 2 No Director Harford Maryland Aberdeen 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number 5 items 23a 312 Fords Lane 21001 Funeral USA Pages 1 and 2 should be filed within 72 hours after death v nent of Health and Mental Hygiene. 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married 2 X No Yes Baltimore, Maryland 21215-0036 'naturai", or 1 ☐ Yes 2 XNo If Yes, Give Year or Dates Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) 12 Owner/Operator Heavy Fourment marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles James Sonberg Jr. Helen Ann Zawadsky ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, Cify or Town, State, Zip Code) Margaret R. Sonberg / Wife 312 Fords Lane, Aberdeen, MD 21001 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any injury or otl 1 Burial 2 Cremation 3 Removal from State 5 Other (Specify) Hilltop Service Corp. 4 Donation 2-7-11 Towson, Maryland 21. Signature of Fune al Service License 22. Name and Address of Facility
McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, MD 21009 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complication Immediate Cause (Final disease or condition resulting in death) SCPSIS

Due to (or as a consequence of): **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death Pregnant at time of death Ectopic pregnancy Month Day in the past 12 months? 5 Other (specify) 2 🗌 No Unknown the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed has 2 No 2 No 1 Yes certificate 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 4 \sum Nursing Home Hospital: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) ည this 27. Manner of Death 1 Natural 28c. Injury at Work? 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Certification: (Month, Day Year) Injury 5 Pending investigation 1 🗌 Yes 2 No 2 Accident Director: Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (check only one) within 2 To the i 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified RES - 000 03 2011 rebruary 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe St, Baltimore, MD, 21287 Satish
31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 0.8 2011 Registrar

DHMH 17 Rev 1/2001

Box 68760.

P.0.

Division of Vital Records,

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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No.	Tay of		-		1	1	į.	-

		1- For State Registrar	Ce	rtificate of Dea	ath	No.		
Physicia Medical Exami	ın/	Decedent's Name (First, Middle,Last)     ANDRZEJ		SZYBIST	Y	2. Date of Death	Day Year	3. Time of Death 1910 hrs
•		4a Facility Name (if not institution, give s		Ess			4c. County of Death Baltimore Cou	inty
Funeral Director		L	7. Age (In yrs. 1 2 F	Mor	nder 1 Year If Under 24H oths Days Hours Mi	_	9. Bir 1973 Society 1973 Co	thplace (State or pn POLAND untry)
and show any ncc.	'n	Usual Residence of Decedent  10a. State 10b. County  MD. BALTIMOF		, Town or Location  ESSEX				10d. Inside City Limits  1 Yes 2 No
with the Maryland ms 23a or 28a-f sho be notified at once.	Director	10e. Street and Number 118 LONG COVE I	ANE		ip Code 21221-1741	100	POLAND	ntry?
fter death with I", nr items 2: er must be n	/ Funeral	1 XXNever Married 2 Married	2. Was Decedent Ever in U Armed Forces? 1 Yes 2 X No Yes, Give Year		dent of Hispanic Origin? ( scify Cuban, Mexican, Puerl		White, etc.	ican Indian, Black,
215-0036 be filed within 72 hours after death with the Maryland nial Hygiene. rked nither than "natural", nr items 23a or 28a-f shent, the Medical Examiner must be notified at once	Completed by	15. Decedent's Education (Specify only  Elementary/Secondary (0-12)  12TH	r Dates: highest grade completed) College (1-4 or 5+)	during most of w	al Occupation (Give kind of orking life. DO NOT use re		16b. Kind of Business/	
21215-0036 uld be filed within 7 Mental Hygiene. marked other that	a	17. Father's Name (First, Middle, Last)  WALENTY SZYE	BISTY		WLAD	ne (First, Middle, Ma	CHMIEL	
MD and 2 sho salth and 2 sh raumati	٩	19a. Informant's Name/Relationship (Typ WIESLAWA CYGANOW 20a. Method of Disposition	ISKI/SISTER	2380 LI	SS (Street and Number or EARMONTH LA	NE MILE	•	48381
Baltimore, permit. Pages la Department of He Impurtant: If its injury or other the		1 Burial 2 XCremation 3 4 Donation 5 Other Specify: 21. Signature of Funeral Service Licenses		YVIEW CRI	EMATORY 7,	,2011		E, MARYLANI
ញ់ ទី ១ គឺ ឆ្នាំ Physician		23a. Part I. Enter the disease, or complicate failure. List only one cause on each	ations that caused the death line.	1201	DUNDALK AV	ENUE BA	LTIMORE,	MD. 21222 Approximate Interval Between Onset and
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Box 68760, e death certificate be the attending physicied for use as the burned for use	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of preg  1 Live birth 4 Pregnant at time of de	2 Fetal deat		ancy	23d. Date of delivery Month E	ay Year
i, P.O. B ires that the d signed by the	ρ	Part II. Other significant conditions co	ontributing to death but not r	esulting in the underlyi	ng cause given in Part I.		acco use contribute to	
tal Records, tian: The law requir certificate has been s ector, page 2 should	Completed					24a. Was ar autopsy perform 1  Yes 2	prior to death?	topsy findings available completion of cause of
Division of Vital Records, P.O. Box 687  To the Hospital in Attending Physician: The law requires that the death certificate the function after death  To the Funcral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	To Be	1 Yes 2 No	pital: 1 Inpatient 2 28a. Date of Injury FOUNDITY Day, Year)	ER/Outpatient 3 28b. Time of Injury	26.Place of Death (Check DOA Other Nursi 28c. Injury at Work?	ing Home 5 R	esidence 6 Other	: Scene
Division pital nr Attendi ours after death teral Director:	Certification:	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be determined	FOUND: Feb 5, 2011 28e. Place of Injury - At h (Specify) Multi-Fami		1 Yes 2 No	28f. Location (Str or Town, Sta	eet and Number or Ru	rat Route Number, City
To the Hospital within 24 hours To the Funeral completely filled	Medical Ce	29a. Certifier (Check only one) 2 Medical Examiner: O	To the best of my knowled	ge, death occurred at the		d due to the cause(	s) and manner as state	ed.
P 3 F 3	¥	29b. Signature and title of certifier	of certifier  29c. License number 29d. Date signed (Mc February 6, 201					
5V			stant Medical Examin	er 900 W. Balti	more Street, Baltimo	ore, MD 21223		
St: Regist		31. Date filed (Month, Day, Year)	32. Registrar's Signatu	all				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death 2. Date of Death 3. Time of Death Physician/ FEBRUARY E MARVIN ΰ3. 2011 POE SKLAR 4:13 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 4001 OLD COURT ROAD, BALTIMORE #418 BALTIMORE Social Security Numbe If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 🗓 M 2 🗆 F Hours Country) Director 213-20-7942 1072871925 85 MD Usual Residence of Decedent 28a-f show 10a. State 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2x No MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4001 OLD COURT ROAD, #418 21208 USA 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces? Black, White, etc. à 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: "natural", 3 ☐ Widowed 4 ☐ Divorced If Yes, Give Completed Specify. Year or Dates. WHITE or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) 5+ ATTORNEY LAW Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည SKLAR BESSIE KRAUSE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health a item 27 i ELINOR SKLAR/WIFE 4001 OLD COURT ROAD, #418, BALTIMORE, MD 21208 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or ot 20c. Location - City or Town, State 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE HEBREW CEM 02/06/2011 REISTERSTOWN, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ year disease or condition CONGESTNE HELRIT Medical resulting in death) Due to (or as a consequence of): Examiner 21 ATRIAL FIBRILL Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence on: or Attending Physician: The law requires that the death certificate be executed the burial-transit VALUULAR that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 d. IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Pregnant at time of death Month Day Year signed by the a 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 1 🗆 Yes 2 X No Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 K Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred eral Director: After filled in by the funer 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital within 24 hours

To the Funeral Medical 29a. Certifier 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. The desired in the least of the state of the 29b. Signature and title of certifier

State Registrar

31. Date filed (Month, Day, Year) 32. Registrar's Signature

7, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) R DAHLHUN, MD;

44000

FEB 0 8 2011

D0054653

2360 W JOPPA RD-STE 210; LUTHERVILLE, MD 21093

29d. Date signed (Month, Day, Year)

FEBRUARY 3, 2011

Amend #16 b per Fh G912 2/8/11/ TT Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ COLUTTA SUSTA KOWSKI JAN 4.15PM Medical 201 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death HCG columbia Howard 7. Age (In yrs. last birthday) 7.4 Yrs. If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 279-30-6495 1 M 2 N (Month, Day, Year) Hours Director OH Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Funeral Director 10d. Inside City Limits notified 28a-f OH Cuyahoga Cleveland 1 Yes 2 No 10e. Street and Number 4603 Wichita Avenue ò 10g. Citizen of What Country USA 10f. Zip Code ed other than "natural", or items 23a or event, the Medical Examiner must be 44144 permit. Page 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must b. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ Ho If Yes, Give Year or Dates. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. ģ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 XXINo Specify: Completed 3 Widowed 4 □ Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b\_Kind of Business Industry
Paint/Varnish Company (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Secretary Mary-<del>Veszelt</del> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Mary Veszelt ပ္ Michael Spisak 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

/ Daughter 4025 Wallings Rd North Royalton Cindy R. Sostakowski 20b. Place of Disposition (Name of cemetery, crematory or other place)
Holy Cross Cem. 20a. Method of Disposition Date 20c. Location - City or Town, State 1 🗆 Burial 2 🗀 Cremation 3 🗶 🕱 emoval from State 1/19/20 Cleveland OH 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Charles L. Stevens Funeral Home, Inc.
501 E. Fort Ave, Baltimore MD 21230 Victor Doda 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): Hospital or Attending Physician; The law requires that the death certificate be executed iding physician and use as the burial-tran resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 use as i IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ 23d. Date of delivery in the past 12 month ō Month Pregnant at time of death Day Year signed by the and be detached for 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24a, Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 s performed? Yes 2 No certificate 2 🗆 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Certificate: To 1 🗌 Yes Other: 1 Impatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this 4 Nursing Home 5 Residence 6 Other (Specify) completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c, Injury at work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending injury Gural Accident Suic 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) mo 059556 1 1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lolumbia 31. Date filed (Month, Day, Year) Fegistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. = For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February Frank C. Tringali 2011 2:20 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Center Baltimore Towson **Funeral** Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Day, Year) 1922 1**y** M 2 □ F Months Days Hours Min New York Director 089-16-9085 Aug 6, 88 Usual Residence of Decedent show ould be filed within 72 hours after death with the Maryland to Mental Hygiene.

marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County must be notified at 10c. City, Town or Location Director 10d. Inside City Limits 28a-f Maryland 1 Yes 2 No Howard Ellicott City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 3004 North Ridge Road #H320 21043 United States or items . Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Armed Forces?
1 XYes 2 No Black, White, etc. 1 Never Married 2 Married à Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. "natural" Completed 3 X Widowed 4 Divorced Specify: White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 <u>Computer Systems</u> Analyst Federal Government permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked ott any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Domenico Tringali Rosa Russo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dominick D. Tringali/son 320 W. College Terrace Frederick, Maryland 21701 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 
Burial 2 
Cremation 3 
Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 2/9/2011 Woodbine, Maryland of Funeral Service Licenses 21. Signati Sing Home Cremation Service P.O. Box 784 M00957Beverly L. Heckrotte, P.A. mas Clarksville, MD 21029 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1 Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Medical resulting in death) Due to (or as a consequence of Examiner LOW Sequentially list conditions, if any leading to in recipite cause. Enter Underlying Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and use as the burial-transi Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician I be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death Year Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 Completed 1 Yes 2 No 3 Probably 4 Honknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy 2 No 1 ☐ Yes 2 ☑ No 1 Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes Certificate: To Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 5 Pending injury 2 Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined Medical Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD 7104 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar ATHT

FEB 08

Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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-	Medi	cal		hristophe not institution, give		fts	,				Februa:		34 2011		<b>1</b> 4 A ™
-	Exami	ier		Wexford R				4b. City, Town, o Baltimo		n of Death		4	c. County of Dea	th	
	Funeral Director		5. Social Security N 021-34-9	020	ex 7. Ag	e (In yrs. Ia 64	ast birthday) Yrs.	If Under 1 Year Months Days	If Und Hours	der 24 Hrs. Min.	8. Date of Bin (Month, Dans)	th ly, Year	9. Bi Co Ne	thplace (State ountry) W York	or Foreign
	and show	Į.	Usual Residence of 10a. State	10b. County		10c. Cit	y, Town or Loc	ation						10d. Inside (	City Limits
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Maryland 21215-0036	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f show, the Medical Examiner must be notified at	by	1 ☐ Never Marr 3 ☐ Widowed	100	1 ☒ Yes 2 ☐ If Yes, Give Year or Dates.	No	1	Yes, specify Cuba	Speci		Hican, etc.)		Black, Whi	e, etc. nite	
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aryl	should be file and Mental H is marked o aumatic eve			ame/Relationship (T)	rpe, Print)		19b. Mailin	g Address (Street					or Town, State, Z	p Code)	
	ge 1 and 2 should be to of Health and Men If item 27 is marke or other traumatic			e Tufts/	Wife	· · · · · ·		Wexford	Rd.	Balti	more, l			<u>-</u>	
nor	age 1 age 1 agent of H			Cremation 3	Removal from State	0	emetery, crem	sition (Name of atory or other place			ate		Location - City or	·	
Baltimore,	permit. Page 1 and 2 st Department of Health a Important; If item 27 is any injury or other trai		21. Signature	1 1/1//		H11		ervice C Name and Addres Ruck 1050		2-8-1 son Fu			owson, M	J.	
			23a. Part 1. Enter t	he dise so, or comp	olications that caused	the death	h. Do not ente	1050 r the mode of dyin	YORK ig, such a	Rd.	TOWSON respiratory ar	ML rest,	21204	Approxima	
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Box	Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours alter death.  Funeral Director, Fether this certificate has been signed by the attending physician and Funeral Director, Pether this certificate has been signed by the attending bhysician and sted filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent in the past 12 r 1 Yes 2 9 Unknown	nonths?	1 Live Birth 4 Pregnant at 9 Unknown	2 🗌 Feta	I death 3	Ectopic pregnand Other (specify)	У				23d. Date of de Month	,	Year
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cord	law require has been si le 2 should b	Completed									24a. Was	osy	prior to	topsy findings	
I Re	iician: The la certificate ha ector, page		25. Was case referre	d to medical				00.00	(D		1 🗆 Yes	rmed?	death?	2 🗗 No	
Vita	hysician: nis certific I director,	To Be	examiner? 1 \(\sum \) Yes 2 \(\begin{align*}		lospital: 1	ent 2 🗆 I	ER/Outpatient	Othe	٥٢.	eath <i>(Check</i> Nursing Hor		lence	6 ☐ Other (Spec	ify)	-
on of	nttending Ph death. ctor: After th y the funeral	icate:	<ol> <li>Manner of Death</li> <li>1 ✓ Natural</li> <li>2 ☐ Accident</li> </ol>	5 Pending Investigation	28a. Date of injur (Month, Day	Y Year)	28b. Time of injury	28c. Injury work M 1		- 1	8d. Describe h	ow inju	ry occurred		
Division of Vital Records,	al or Atte s after de il Directo d in by th	Certificate:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of Inju building, etc.			et, factory, office		2	8f. Location (S City or Tow		nd Number or Ru e)	ral Route Numi	ber,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completed filled in by the fo	Medical	(Check 2	Medical Examin	ician: To the best of r ner: On the basis of ex e Practioner: To the b	amination	and/or investig	gation, in my opinio	n, death	occurred at t	he time, date a	nd plac	e, and due to the	cause(s) and ma	anner stated.
	To t With To tl		29b. Signature and t	itle of certifier	Q. 11	0		29c. License		1 /		29d. Da	ate signed (Monti	, Day, Year)	
	1	-	30. Name and addre	ss of person who co	Impleted cause of be	athultem	23a) (Type, Pri	1 0/9				7	7/11		
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			For State Registrar		State of Ma	aryıan		artment of i tificate of i	Health and I Death	vientai Hy	Reg. No.	J 1	13351	
	Physicia	n/	1. Decedent's Name (Firs		•			-		2. Date of De	eath Dav	Year	3. Time of Death	
	Medic Examin	cal	CHARLOTTI  4a. Facility Name (if not in			ARSES	5	4b City Town o	r Location of Death	Februa	ary C	OZ ZOII	10:28 A M	
	Z	ici	Sinou Ho	spital	of Balti	MOY	e	Baltin	nore Ci	t1/	40.0	N/A		
	Funeral Director		5. Social Security Number 214-30-684	4.1	x 7. Age ☐ M 2 ☐ XF	e (In yrs. Ia 92	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bit 09/03/	rth av. Year) 1918		thplace (State or Foreign untry)  MD	
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	larylan 3a-f sh iffied a	Director	MD 100.	N/A			ALTIMO						10d. Inside City Limits 1   Yes 2 □ No	
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	ath witi	Funeral	3011 FALLS	STAFF R	OAD, #307 12. Was Decedent E	ver in U.S	I 13. V		209	ecify Yes or No-		USA 4. Race - Ame	rican Indian	
98	within 72 hours after death with the Maryland jiene. 9r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	þ	1 Never Married 2		Armed Forces? 1 ☐ Yes 2 🛣 If Yes, Give		<ol> <li>Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto</li> <li>Yes 2 X No Specify:</li> </ol>			Rican, etc.)		Black, White	e, etc.	
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Maryland			19a. Informant's Name/R		•	1		and Number or Ru		-				
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Bal	permit. Departr Imports any inji		21. Sighature of Funeral S	ruger	OL LEVI ROAD, P			•						
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between											
	Pnysician/ Medical		Immediate Cause (Final disease or condition resulting in death)	_	a Acute		youar	dial	infarct	ion			2nset and Death	
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Box 68760	certific anding puse as	JW/We	IF FEMALE: 23b. Was decedent pregr	nant 2	23c. If yes, outcome	of pregnar	ncy	Ectopic pregnan			23	3d. Date of del	ivery	
	nat the death certificate be ed by the attending physici detached for use as the bu	Physician/Medica	in the past 12 month 1  Yes 2  No 9  Unknown		4 Pregnant at 9 Unknown			Other (specify)				Month	Day Year	
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ords	w requii	Completed by	- ciyperi	Erisio						24a. Was	an	24b. Were aut	topsy findings available	
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Vital	ysician s certifi director	To Be	25. Was case referred to rexaminer?  1 \sum Yes 2 \sum No	100	lospital:	ent 2	ER/Outpatien	Toth	er:	ome 5 ☐ Resi	dence 6	Other (Spec	ifu)	
Division of Vital Records,	nding Physician: ath. : After this certific e funeral director,		27. Manner of Death  1 ☑ Natural 5 ☐ 2 ☐ Accident	Pending Investigation	28a. Date of injur (Month, Day	у	28b. Time of injury	28c. Injur worl	y at	28d. Describe				
)ivisio	I or Atten after deat Director: d in by the	Certificate:	3 Suicide 6 4 Homicide	Could not be determined	28e. Place of Inju building, etc			et, factory, office		28f. Location ( City or To		Number or Rui	ral Route Number,	
	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the but the but the funeral director.	Medical	(Check 2 D M	ledical Examin	ician: To the best of oper: On the basis of example of the basis of example of the basis of example of the basis of example of the basis of example of the basis of example of the basis of example of the basis of example of the basis of example of the basis of example of the basis of the basis of the basis of example of the basis o	camination	and/or invest	igation, in my opini	on, death occurred a	at the time, date	and place, a	nd due to the o	cause(s) and manner stated.	
	To the within 2 To the comple		29b. Signature and title of	of certifier	en 12	1)		29c. Licens	e number		←	signed (Month		
			30. Name and address of		ompleted cause of de	eath (Item			to Coital	A RA	1 tring	uary ore		
	Stat Registra	100	31, Date filed (Month, Day		32. Registra	r's Signat		doct	10-prial	01 130	<u> </u>	<u> </u>		
	-34			/44		- CT								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2011 Physician/ Michael Month Edwin 7:53 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford Memorial Hospital Havre de Grace Harford Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Country) Maryland (Month, Day, Year) lay 18, 1940 1**X** M 2 □ F Months Days Hours Min Yrs **Director** May 217-36-3667 70 Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Harford Havre de Grace 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3730 Greenspring Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates. þ 1 Never Married 2 Married 72 hours after 1 ☐ Yes 2 XNo Specify: Completed Specify: 3 Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working filed within 72 tal Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Engineer U.S. Government other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fil. Department of Health and Mental Important; If item 27 is marked of 2 Oliver John Vogel Dorothy Roberta Noonan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 92 Merrimack Dr., Merrimack, New Hampshire, 03054 Eric M. Vogel / Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) injury or Bel Air Memorial Gdn. 2/4/2011 4 Donation 5 Other (Specify) Bel Air, Maryland any in 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Atherosclerosis -oronary disease or condition resulting in death) Medical Due to (or as a consequen of) **Examiner** abetes Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury for as a consequence on Hospital or Attending Physician: The law requires that the death certificate be executed tension that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Dav Pregnant at time of death 1 Yes 2 g Unknown 2 No 9 Unknown signed by ti Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an Jas autopsy death? certificate l 1 ☐ Yes 2 ☐ No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 Yes 2 No Other: မြ 1 Inpatient 2 XER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) Division of 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number Homicide determined City or Town, State Medical 🕊 certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature ar 0039258 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 615 W. Mac Phil #206 Bel Ar MD 21014 Laurence D. white MAD 31. Date filed (Month, Day, Year) Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar	tate of Maryland / I		ificate of		ia mon	itai riygi		g. No.		
Physicia Medical Exami		Decedent's Name (First, Mid						l 1	Date of Deat Month	Day	Year	3. Time of Death 0234 hrs
vieuicai Exami	ner	CINDY  4a. Facility Name (if not institut	Mae			Varg			ebruary 5		County of Death	
		30905 Johnson Road				Salisbury					comico	
Funeral		5. Social Security Number	6. Sex 7. Age (I	In yrs. las	t birthday)	If Under 1 Ye			Date of Birt	h (MM/DE	D/YYYY) 9. Birt Foreig	hplace (State or
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any .		Usual Residence of Decedent 10a. State 10b. County	/ 10	C. City, T	own or Locati	on						10d. Inside City Limits
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Maryland 28a-f show	Director	10e. Street and Number		502151	, a. j	10f. Zip Code			10	g. Citizer	n of What Coun	itry?
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72 hours after death with the Maryland n "natural", or items 23a or 28a-f she al Examiner must be notified at once	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)								14	<ol> <li>Race - Americ</li> <li>White, etc.</li> </ol>	can Indian, Black,	
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	8	James	н.		Merr			ez		R.		Brown
	유	19a. Informant's Name/Relation		10						ber, City	or Town, State,	Zip Code)
<b>=</b> e = e		Doreen Yackel, S:	ster		ace of Disposi	ech Stree		Td, NY I		20c. Loc	cation - City or	Town, State
Baltimore, permit. Pages I an Department of He Important: If ite			on 3 Removal from State		ematory or oth radford	er place)		02/10/	′2∩11	C I	Waverly,	DΛ
Baltin Permit. P Departme Importan Injury or		4 Donation 5 Other 3 21. Signature of Funeral Service		IN. D		ame and Addres	s of Facility				k, Inc.	ra
		Cleandra &	Han			05 Harfor		, Baltin	nore, Mi	D 212	14	
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Sox 687 leath certific e attending for use as t	ian/	23b. Was decedent pregnant in past 12 months?	1 Live birth Pregnant at time	e of deat	, - <del>-</del>	al death 3	Ectopic	pregnancy		Mo	onth D	ay Year
Box e death the atte	Physician/	1  Yes 2 No 9 ✔ Ur			⊃ ∐ Oth	er (Specify)						
bat the ed by t	by P	Part II. Other significant condi	tions contributing to death bu	ut not resi	ulting in the ur	derlying cause	given in Pa	ırt I.				he cause of death?
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Cords law requi	Completed								autops	y I		opsy findings available ompletion of cause of
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/ital	o Be	examiner?	Hospital: 1 Inpatient	2 E	R/Outpatient		Othor	(Check only only only only only only only only		Residence	e 6 🗸 Other:	Scene
of \ing Ph	⊢ŀ	27. Manner of Death	28a. Date of Injury (Month, Day, Year)	2	8b. Time of In	ury 28c. Inju	ıry at Work	? 28d.	. Describe h	ow injury	occurred	
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Hospit 24 hour Funer: ely fill		4 Homicide  29a. Certifier 1 Certifying F	Physician: To the best of my kn	nowledge	death occurre	ed at the time, d	ate and pla	ice, and due	to the cause	e(s) and m	nanner as state	d.
Division  To the Hospital or Attend within 24 hours after death To the Flueral Director: completely filled in by the i	Medical		aminer: On the basis of examina and manner stated.									
	Ĭ	29b. Signature and title of certifi				29c. Licens					te signed (Moni	th, Day,Year)
		Lard	- Hall	du		0.0.	M.E.			⊢ebru:	ary 5, 2011	
RV	-	<ol> <li>Name and address of person</li> <li>Carol Allan, MD As</li> </ol>	n who completed cause of death sistant Medical Examin	,	,	more Street	, Baltimo	ore, MD 2	1223			
Sta		31. Date filed (Month, Day, Year)	_									
Registr	rar	FEB 0.8 2011	De con A	ho	41							

DHMH 17 Rev 1/2001 OCME 2006

OCME

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Dav Year Veth Month Madilyn 1:30 Pm 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Upper Chesapeake Hospital Bel Air Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) New York 8. Date of Birth **Funeral** 7. Age (In vrs. last birthday) Days Hours Min. (Month, Day, Y 1 M 2x Director 050-18-2510 7,1924 86 Sept. Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2x No MD Harford Air Be1 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? items 23a Funeral 1306 Allenby Court 21014 Unites States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, o þ 1 Never Married 2 Married Yes 2 X No Yes, Give Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. "natural" Completed 3 XWidowed 4 Divorced Year or Dates White other traumatic event, the Medical Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Years Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) f Health and Mental I မ Henry Brokate Agnes Kelly 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1306 Allenby Court Page 1 and 2 Jennifer V. Alexander (Daughter) Bel Air, Maryland Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 Department of Important: If it ō injury or ( cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sacred Ht of Jesus Cem. 2/4/2011 Dundalk, Maryland 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 21. Signature of Funeral Service License Part 1. Enter the disease of complications that cau shock, or heart failure List only one cause on each complications that caused the death. Do not enter the mode of dy/g, such as cardiac or respiratory arrest, Interval Between Immediate Cause (Fixal aset and Death Ph\_sician/ 4 02 disease or condition Medical resulting in death) Examiner V05 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as Examir Cause (Disease or iinjury that initiated events page 2 should be detached for use as the burial-tran Due to (or as a cops resulting in death) Last cuence of Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? 4 ☐ Pregnant at time of death g ☐ Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1  $\square$  Yes 2  $\square$  No 3  $\square$  Probably 4  $\square$  Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has autopsy performed certificate 1 Yes 2 No Yes 2 Hospital or Attending Physician: 7 24 hours after death. Funeral Director: After this certifics the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No Hospital Other: မ 1 Tyes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred injury 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined building, etc. (Specify) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical graminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

State

within 2 To the F

(Check

29b. Signatu

only one)

Date filed (Month, Day, Year)

FEB 08

Registrar

1308 Business

erson who completed cause of death (Item 23a) (Type, Print)

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Reg. No. 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 8: 10 P. M Robert Gordon Wingate, PERRUARY Medical 4c. County of Perile | L 4a. Facility Name (if not institution, give street and VA MARY LAND HEALTH Examiner HEALTH CARE SYSTEM KNOWN TO PHYSIEIAN: WINGATE, ROBER Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Nov 16, 9. Birthplace (State or Foreign Country) **Funeral** 1 XM 2 □ F 212-26-6791 1930 Maryland Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD N/A Baltimore City 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21230 1510 Olive Street United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. XYes 2 No 1950-Yes, Give þ 1 Never Married 2 Married NAME KNOWN TO PHYSICIAN:
Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Completed 3 Widowed 4 Divorced Specify: White 1952 Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 10 Carpenter Contracting Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Harvey Wingate Gordice Madeline Pritchett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandra Leyva Daughter 1607 Airy Hill Ct., Crofton, Maryland 21114 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc 02/07/2011 Baltimore, Maryland Signature of Funeral Service Licensee Alyson K Taylor 22. Name and Address of Facility Cremation Society of Maryland 299 Frederick Rd., Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. PNEUMONIA Immediate Cause (Final PINKHOWN Physician/ disease or condition resulting in death) Medical "083"TRUCTIVE PULMONARY\_DISEASE **Examiner** UNKNOWN Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Exami attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) Day Year been signed by the should be detached a 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has performed? Yes 2 N this certificate 1 Yes 2 No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 🕅 Nursing Home 5 🗆 Residence 6 🗆 Other (Specify) 1 Yes 2 X No 욘 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at After 1 Natural 5 Pending after death.

Director: Aft
d in by the fur 1 Yes 2 No Accident Suicide Investigation 6 Could not be To the Hospital or Atte within 24 hours after de To the Funeral Directo completed filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🙎 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated з 🗍 only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier FEBRUARY 5. MID: VA MARYLAND HEALTH CARE SYSTEM, PEARY MINT, 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February 2011 Wienke 10:58 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Oak Lodge SeniorHome Assisted Living Pasadena Anne Arundel 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) Nov. 13,1920 New Jersey If Under 1 Year | If Under 24 Hrs. Social Security Number **Funeral** 6. Sex . Age (In yrs. last birthday) Hours 1 🗆 M 2 💢 F Director 130-01-6095 90 Usual Residence of Decedent 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho ury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location Funeral Director 1 🗆 Yes 2 🛣 No Anne Arundel Pasadena Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 402 Sylview Drive 21122 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: 3 XWidowed 4 ☐ Divorced Year or Dates Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) N 'A Elementary/Seconday (0-12) 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Klimaszewska Adele Firko 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas Wienke (Son) <u> 203 Hickory Point Road Pasadena, Maryland 21122</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 🛣 Burial 2 🗀 Cremation 3 🗔 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cem. 02/09/2011 Brooklyn Park, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, strick, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Chronic Penal disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Humerteuston rats Sequentially list conditions, Examine or as a consequence of cause. Enter Underlying signed by the attending physician and d be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗌 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Pregnant at time of death Month Dav Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by I Records, 1 Tes 2 No 3 Probably 4 Unknown Alzheimer's demention 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Tes To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifice Division of Vital completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) Other (Specify) \( \text{A441512d Liv.} \) 1 ☐ Yes 2 ☐ No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) ee, m MUSICIAIN 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) catonsville MD 21228 700 Gentamin S. Lee, W.D

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

FEB 0 8 201

32. Registrar's Signature

101

State 31. Date filed (Month, Day, Year)
Registrar FEB 0 8 2011

32. Registrar Signature

Assistant Medical Examiner

900 W. Baltimore Street, Baltimore, MD 21223

30. Name and address of person who completed cause of death (Item 23a)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar		State of Ma	aryiand /		rtment of F rtificate of I		,	giene Reg. No.	2111111	03388		
	Dhysisi		1. Decedent's Name (First,	Middle, Last)						2. Date of Dea	ath Day	/ Year	3. Time of Death		
	Physici /Medic		Donald R.	Wickess	er, Sr.					Februar			7:00A <sup>M</sup>		
The same	Examin		4a. Facility Name (If not ins	-				4b. City, Town, or	Location of Death	ו	4c.	County of Death			
			6126 Wheat					Catonsv		Baltimore					
	Funeral Director		5. Social Security Number 212–26–9068		M 2DF	e (In yrs. last l	Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da July 28	h y, Year) , 19	9. Birth Cou 931 Mar	place (State or Foreign intry) yland		
	ryland how		Usual Residence of Deceder 10a. State 10b. C			10c. City, To	wn or Lo	cation					10d. Inside City Limits		
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	or 28	Dire	10e. Street and Number			-		10f. Zip Code			10g. Cit	izen of What Cou	intry?		
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21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, if a Modical Examination is profiled at once.	Completed by Funeral	11. Marital Status 1 □ Never Married 2 ☑ 3 □ Widowed 4 □ Div	☑ Married	2. Was Decedent E Armed Forces? 1			Vas Decedent of H fYes, specify Cuba □Yes 2 ☑ No		pecify Yes or No- o Rican, etc.)		14. Race - Amer Black, White, Specify:			
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	and 2 sl lealth an m 27 is r her traur		Greta Wicke					Wheatlan							
Baltimore,	f Healifem		20a. Method of Disposition			20b. Place	of Dispos	sition (Name of natory or other place	-1	Date	20c. Lo	ocation - City or T	own, State		
E O	Pages nent of lant; If ite		1 ☑ Burial 2 ☐ Crem 4 ☑ Qonation 5 ☐ Ot		moval from State			v Mem. Pa		/2011	Syke	esville,	MD		
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			21. Sonaire of Funeral Service License  22. Name and Address of FacilitySterling Ashton Schwab Wiffuneral Home of Catonsville, Inc.  1630 Edmondson Avenue; Catonsville, MD 2  23a. Part 1. Enter the disease, or conficiations that caused the death. To not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												
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æ,09∠89	tificate be executed g physician and as the burial-transit	ledical		d.											
	the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death.  The Funeral Director: After this certificate has been signed by the attending physician and ripletely filled in by the funeral director, page 2 should be detached for use as the burial-transit.	hysician/Me	IF FEMALE: 23b. Was decedent pregna in the past 12 months 1 □ Yes 2 □ No 9 □ Unknown	ant j	c. If yes, outcome of the line	2 🗌 Fetal dea		Ectopic pregnanc	y			23d. Date of deliv	very Day Year		
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al Rec	tending Physician: The law seath.  tor: After this certificate has be the funeral director, page 2 sl	Completed								24a. Was autop perfor 1 □Yes		prior to co death?	opsy findings available ompletion of cause of 2 No		
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	10	ŀ	30 Name and address of p	erson who com	pleted couse of de	eath (Item 23a	ı) (Type, f		0 4	1	101	0 1 1	2011		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Karen whyte 12:30 AM FEBRUARY Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore Randallstown Northwest Seasons Hospice 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 □ M 2 🕱 F Months Hours Min (Month, Day, Year) 217-62-1716 56 MD **Director** Usual Residence of Decedent 28a-f shov 10a. State 10c. City, Town or Location 10d. Inside City Limits death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at Director 1 X Yes 2 □ No Baltimore MD NA 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 220 Stonecroft Road Apt."C" USA 21229 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American India Armed Forces?

1 Yes 2X No Black, White, etc. African þ 1 Never Married 2 Married 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2XXNo Specify: If Yes, Give Year or Dates Specify: American "natural", 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than College (1-4 or 5+) Elementary/Seconday (0-12) City of Baltimore 12th Grade Accountant Assistant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Geraldine Holly Quille Joseph permit. Page 1 and 2 should be Department of Health and Men-Important: If item 27 is marke any injury or other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
220 Stonecroft Road Apt."C" Baltimore, MD 19a. Informant's Name/Relationship (Type, Print) Michael Whyte-Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Mt. Zion Cem. 1 Burial 2 Cremation 3 Removal from State 02-09-11 Lansdowne, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility  $Wylie\ Funeral\ Home\ \Gamma.A$  . 638 N. Gilmor Street Baltimore, MD 21217 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Betweer Metastatic Liver cancer Onset and Death Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (or as a consequence of, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events physician and is the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending p for use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No Month Pregnant at time of death
Unknown Day Year signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy performed? Yes 2 death? within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 🗹 No Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \) Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide work? 1 Pes 2 No 5 Pending Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated MS Ray apamem. D 29b. Signature and title of certifier D0057465

State Registrar 31. Date filed (Month, Day, Year)

FEB 08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
N: S. Rajapakse, M.D. 2835 Smith N-5-203, Baltimer, MD. 21709

214/1)

P.O.

Records.

of Vital

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar 3390 Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month West arie CI, NP 12:45 PM -esruar Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Shady Grove Adventist Hospital Rockville Montgomery 8. Date of Birth (Month, Day, July 25, If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2 🔀 F Months Hours Alabama 420-28-9510 83 Director Usual Residence of Decedent 28a-f show r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🔀 No Maryland Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9432 Emory Grove Road 20877 United States 11. Marital Status Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Armed Forces?
1 ☐ Yes 2 🔀 No by 1 Never Married 2 Married 1 Yes 2 K No Specify: If Yes, Give Specify: 3 XWidowed 4 Divorced Completed White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ပ္ Cline Edwin Ruby permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. D. Stevens 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary M. Quick/daughter 9432 Emory Grove Road Gaithersburg, Maryland 20877 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 2/10/2011 Woodbine, Maryland Signature of Funeral Service Lice Going Home Cremation Service P.O. Box 784
Beverly L. Heckrotte, P.A. Clarksville, MD 23a. Part T Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Cardiopulmonary disease or condition resulting in death) Medical Examiner Myocardial Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of): the burial-transit law requires that the death certificate be executed Pneumonia and that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical attending properties for use as 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Day 1 Yes 2 D signed by the a g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2 N has or Attending Physician: The certificate 1 Yes director. 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Tyes ပ 1 Inpatient 2 ER/Outpatient 3 DOA this filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide After 5 Pending work?
1 Yes 2 No death. Investigation 6 Could not be 24 hours after deal Funeral Director: 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 20a Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2. To the F 29b. Signature and title of certifier on who completed cause of death (Item 23a) (Type, Print) Medical Car Dr Rockville, MD 20850

State Registrar

DHMH 17 Rev 7/2009

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Morcos HO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Louise M. Wagner February 07, 2011 5:00 A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Oak Crest Care Center Parkville Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day October 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Days Min 1 □ M 2 🗓 F 87 Hours Lake Lynn, PA 217-20-2646 **Director** Usual Residence of Decedent f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Nottingham 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4480 Cole Farm Road 21236 United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Yes 2 XNo Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 TNo Specify. 3 X Widowed 4 Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Clerk State of Maryland N/A Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ John Stager Mary Markl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Wagner, Jr. Nottingham, Maryland 21236 (Son) 4480 Cole Farm Road 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) Cardens of Faith Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Rosedale, Maryland 21. Signature of Funeral Service Licensee

22. Name and Address of Facility

Evans Funeral Charcel & Cremation

8800 Harford Road Parkville, M

23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause in hald disease or condition. 22. Name and Address of Facility
Evans Funeral Chapel & Cremation Services—Parkville
8800 Harford Road Parkville, Maryland 21234 Approximate Interval Between Onset and Death alzheimers Physician/ Duease disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attending physician and I for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 21 No Month Year Pregnant at time of death signed by the a g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Cardiomyopathy Division of Vital Records, 1 ☐ Yes 2 ☐ Ho 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has page 2 s autopsy performed? death? certificate 1 Yes 2 🗌 No Yes 2 1 funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: မ 1 Inpatient 2 IER/Outpatient 3 IDOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work 2 🗌 No 1 🗌 Yes Accident Investigation after deat Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated the only one 31 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signate e and title of certifie 29d. Date signed (Month, Day, Year) R171944 2011 CKM, MSN

Registrar

State

30. Name and address of pers

8

31. Date filed (Month, Day,

Harrison

Blvd, Parkville MD 2/234

on who completed cause of death (Item 23a) (Type, Print)

11-00994 William Vi Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Villiam Yi	State of Maryland / Departmer 1-For State Certificate Registrar	lene 2011 03392	
Physician/ Medical Examine	1. Decedent's Name (First, Middle,Last)		Date of Death Month Day Year February 5, 2011  3. Time of Death 0644 hrs
ggarour Examine	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
Formul	Prince George's Hospital  5. Social Security Number 6. Sex 7. Age (In yrs. last birthdo	Cheverly  If Under 1 Year If Under 24Hrs. 8	Prince George's  Date of Birth(MM/DD/YYYY) 9. Birthplace (State or
Funeral Director	218-37-3362 12M 20F	Months Davis Hours Min	June 4, 1992 Foreign Country) MD
b.	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or		10d. Inside City Limits
P P	M) Mantagard Silv	er Spring	1 Ves 2 No
Aaryland 28a-f show 1 at once. ector	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
or death with the Maryland or tiems 23a or 28a-f sho caust be notified at once. Funeral Director	2012 Sandstone Ct	20904	USA
items	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No	<ol> <li>Was Decedent of Hispanic Origin? (Specif If Yes, specify Cuban, Mexican, Puerto Ric</li> </ol>	an, etc.) White, etc.
ج ا <b>خ</b> اء ۾	or Dates:	1 Yes 2 No specify:	specify: ASIQN
2 hours "natur	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4 or 5+)	cedent's Usual Occupation (Give kind of work ing most of working life. DO NOT use retired)	
5-0036 ed within 72 hour bygiene. other than "natu the Medical Exan Completed	12	Student	Education
	17. Father's Name (First, Middle, Last)	0.0	rst, Middle, Maiden Surname)
7 Mes Nes	19a. Informant's Name/Relationship (Type, Print )	failing Address (Street and Number or Rura	Il Route Number, City or Town, State, Zip Code) 20904
Md 2 alth	20a. Method of Disposition 20b. Place of D	Disposition (Name of cemetery,	ate 20c. Location - City or Town, State
AOre ages 1 and of H.	1 Burial 2 Cremation 3 Removal from State crematory	or other place)	12011 Hanover, MD
Baltimore, permit. Pages la Department of He Important: If ite injury or other ti	21. Si Gature of Funeral Service Licensia	22. Name and Address of Facility	- A II -
en ឧក្ខ័ មិន្តិ Physician	23a. Part I. Enter the disease, or complications that caused the death. Do not e	10220 Guilton	l Kal, Jessup, MD 20194
Medicat	failure. List only one cause on each line.  Immediate Cause (Final disease a, Multiple Injuries	. •	Between Onset and Death
<u>E</u> xaminer	or condition resulting in death)  Due to (or as a consequence of):		
ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause		
ted Insit Examiner	CDIsease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):		
		· · · · · · · · · · · · · · · · · · ·	
	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of delivery
Box 6876 e death certificate the attending phy ed for use as the b hysician/M	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 4 Pregnant at time of death	Fetal death 3 Ectopic pregnancy Other (Specify)	Month Day Year
). Box 6876 the death certificate by the attending phyched for use as the Physician/M	1 Yes 2 No 9 Unknown 9 Unknown		
Division of Vital Records, P.O. Box 6876 the Hospital or Attending Physician: The law requires that the death certificate hin 24 hours after death.  the Funeral Director: After this certificate has been signed by the attending phypietely filled in by the funeral director, page 2 should be detached for use as the lical Certification: To Be Completed by Physician/M		the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?  1  Yes 2 ✓ No 3 Probably 4 Unknown
Division of Vital Records, P.O. fallor Attending Physician: The law requires that the stater death.  al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detail artification: To Be Completed by Fartification:			24a. Was an 24b. Were autopsy findings available prior to completion of cause of
he law ate has age 2 sh			performed?  1 Yes 2 No 1 Yes 2 No
ital Releian: The certificate rector, page	25. Was case referred to medical	26 Place of Death (Check only	
n of Vision Physical After this funeral direction on: To	1 V Yes 2 No 1 Impatient 2 V Civoups	e of Injury 28c. Injury at Work? 28c	d. Describe how injury occurred
ion (tending leath. tor: A) the fur	1 Natural 5 Pending Provided Investigation Page 12 Pending Provided Investigation Provided P	7·	ver auto fixed object collision
Division o spital or Attending hours after death.  uneral Director: After the function of the	3 Suicide 6 Could not be determined (Specify) Major Road / High		f. Location (Street and Number or Rural Route Number, City or Town, State) erry Hill Road and Bornedale Drive , Beltsville , MD
Hospits 24 hour Funers tely fills	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death	,	
To the Hos within 24 h To the Fur completely	one) 2 Medical Examiner: On the basis of examination and/or inversal and manner stated.  29b. Signature and title of certifier	stigation, in my opinion, death occurred at the	e time, date and place, and due to the cause(s)  29d. Date signed (Month, Day, Year)
	a wal Held O O M 12	O.C.M.E.	February 6, 2011
61	30. Name and address of person who completed cause of death (Item 23a)		
J*	Carol Allan, MD Assistant Medical Examiner 900 W.  31. Date filed (Month, Day, Year) 32. Registrar's Signature	Baltimore Street, Baltimore, MD 2	21223
State Registra	man a C ages 6	•	

DHMH 17 Rev 1/2001 OCME 2006 OCME

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician. February 6, 2011 3:05 а м Marie Ziomek Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Timonium Baltimore <u>Stella Maris</u> If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 8. Date of Birth 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 1920 Pennsylvania 1 □ M 2 🖵 F Director 187-05-3431 90 Aug. Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Timonium 1 Tyes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2300 Dulaney Valley Road 21093 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: If Yes, Give Year or Dates Specify: White 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business Industry Elementary/Seconday (0-12) 12 College (1-4 or 5+) Accountants Payable Printing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Sumame) Stanley Violet Kulak Buza 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edward Ziomek / son 1557 Doxbury Road Towson, Maryland 21286 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State 2/9/11 4 ☐ Donation 5 ☐ Other (Specify) Overlea, Maryland Gardens of Faith 21. Signature / Funer Servi Lio See 22. Name and Address of Facility 1050 York Road Ruck Towson Funeral Home, Inc. Towson, Md. 21204 ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. 23a. Part 1. Enter the disease, or shock, or heart failure. List on Onset and Death Immediate Cause (Final Ph\_sician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions if any adding to him districture. Enter Underlying Cause (Disease or linjury that initiated events Examine Dise to for as a consequence off Due to (or as a consequence of) resulting in death) Last Physician/Medical or Attending Physician: The law requires that the death certificate be after death. IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Day Pregnant at time of death 5 Other (specify) 9 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No ☐ Yes 25. Was case referred to medical examiner? Division of Vital Be 26. Place of Death (Check only one) Hospital Other: 2 No 잍 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury work?
1 Yes 2 No 2 Accident 3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Keis R 043580 02-07-2011-30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JUSTINE PREIS, CRNP 2300 DULANEY VALLEY ROAD TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 7/2009

State Registrar

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MARTE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Dav Year LIONEL R. ARTHUR М 2011 0845 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death MONTGOMERY WASHINGTON ADVENTIST HOSPITAL TAKOMA PARK 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5 / 2 4 / 1 9 2 0 Sex 1 M 2 □ F 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Min. Director 580-10-5178 90 INDIES Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director ADELPHI PRINCE GEORGE'S 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10a, Citizen of What Country? Funeral 2617 LACKAWANNA DR 20783 UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces? 1 Ves 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 2 1 Never Married 2X Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Completed Specify: BLACK 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) other than College (1-4 or 5+) Elementary/Seconday (0-12) MINISTER PRIVATE it. Page 1 and 2 should be filed with rtment of Health and Mental Hygien rtant: If item 27 is marked other 1 njury or other traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည MARTIN OTIS MARSHALL ARTHUR 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BERT ARTHUR/SON 2617 LACKAWANNA DR. ADEPHI, MD 20783 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 Department of Important: If it any injury or o 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) GEORGE WASH., CEM! 2/13/11 ADELPHI, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility CAPITOL MORTUARY 0144 MARYLAND AVE.. NE WASH.. 20002 23a. Part 1. Enter the disease, or complications that paysed the death. Do not enter the modern of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine been signed by the attending physician and should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IE FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year 1 Yes 2 9 Unknown 2 No Part II Othe contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 124 hours after death.

Funeral Director: After this certificate has the funeral director, page 2 sileted filled in by the funeral director, page 2 sileted filled in by the funeral director, page 2 sileted filled in by the funeral director, page 2 sileted filled in by the funeral director. performed' 1 Yes 2 V No Yes 2- No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: မ 1 🗌 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifies Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signatu 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7600 CARROLL AVE., TAKOMA PARK, 20912 MD. 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year 121 Adriana Alinsod Ø M 20 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death AR AIRHEALTH AND REHABILITATION (eNTER If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Manila **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth 1 □ M 2 🛛 F Months Days Hours Min. 03<u>~04-</u>1921 213-70-2423 89 Director Usual Residence of Decedent items 23a or 28a-f show ner must be notified at 10a. State 10b. County filed within 72 hours after death with the Maryland **Funeral Director** 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 💢 No MD Harford Bel Air 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 840 High Plain Drive 21014 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, the Medical Examiner Black, White, etc. ö à 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: Specify: Asian "natural" 3 X Widowed 4 □ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Accountant Accounting permit. Page 1 and 2 should be filed wit. Department of Health and Mental Hygier Important: If item 27 is marked other tany injury or other traumatic event, the once. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဨ Adriano Flores Unknown Reyes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Daughter) Susana Thomas 840 High Plain Drive Bel Air, MD 21014 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 02-05-2011 4 Donation 5 Other (Specify) Most Holy Redeemer Baltimore, MD 21. Sign it re of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home of BelAir 610 W. MacPhail Rd Bel Air, MD 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line, Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of): Exâminer Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 \( \subseteq \text{ Yes} \) 2 \( \text{No} \) Pregnant at time of death Month Day Year □ Pregnant :
 □ Unknown the 9 🗌 Unknown P.O. b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed 23e. Did tobacco use contribute to the cause of death? A) $\mathcal{L}(A \cup UA) = \mathcal{L}(A)$ Division of Vital Records, 1 ☐ Yes 2 🗙 No 3 ☐ Probably 4 🗆 Unknown page 2 should been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an the Hospital or Attending Physician: The law certificate has 2 🗌 No 1 🗌 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: ၉ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at Natural 2 Accident 5 Pending 1 Yes 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the control my knowledge, dreft occurred at the time, date and place; and due to the narred) and manner stated. (Check 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) MD. D 0063981

State Registrar Havre de (orace, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

669 Revolution

32. Registrar's Signature

Benjamin Lee, MD

31. Date filed (Month, Day, Year)

Eugene	Aaron	Bonacci	

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Eugene Aaion E		1- For State Registrar	36	ate of Maryla		epartment Certificate			ıtaı riygieti		. No.	1 10000	4
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Funeral Director		5. Social Security I	498	6. Sex	7. Age (In yr	rs. last birthday)	Yrs. If Und		a Adim	te of Birth	(MM/DD/YYYY) 9. B Fore C		
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farylar 28a-f s	Director	10e. Street and Nu	mber				10f. Zi	p Code		10g	. Citizen of What Co	untry?	
3a or		925 Wind	wisper	Lane			2	1043		Ţ	J.S.A.		
imore, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland nett of Health and Mental Hygiene. tant: If item 27 is marked other than "natural", or items 23a or 23a-f show or other transmite event, the Medical Examiner must be potified at once.	Funeral	11. Marital Status  1 Never Marri	ed 2 Ma		cedent Ever in orces?			ent of Hispanic Ori ify Cuban, Mexican			14. Race - Ame White, etc.	erican Indian, Black,	
ter dea		3 Widowed		1 X Yes orced If Yes, Give Yes	2∐ No 203–06≖		Yes 2	2X No specify:	:		Specify: Whi	ite	
ours af atural	ğ ğ		-	or Dates: cify only highest grad		i) 16a. Deced	ent's Usual	Occupation (Give	kind of work don	e 1	6b. Kind of Business		-
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than njury or other transments event, the Medical	P	19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State,										te, Zip Code)	
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Depa I	ļ	21. Sign the of Fineral Service Licens 22. Name and Address of Fecility Gut 8000 Jericho Turnpil											
Physician	寸	23a. Part I. Enter	ne disease, or	complications thet con each line. At	aused the dea	ath. Do not ente	r the mode	of dying, such as c	ardiac or respirat	ory arrest		Approximate Interval Between Onset and	1
- Medical Examiner	ı	Immediate Cause (	Final disease	a. Pulmonary	Thromboo	embelism -	Caru	TOVASCUL	ar Disea	.se		Death	
		or condition resulti		Due to (or es a b.	consequenc	e of):							
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Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certifical within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as the	ā	ratti. Calor signi	nounc contain	Jan Contributing to	, death but no	ocresuling in the	e undenym <sub>i</sub>	g cause giver iii r	1[	Yes		bably 4 Unknown	i
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Division To the Hospital or Attency within 24 hours after death To the Funeral Director:	Medical		Medicel Exam	niner:On the basis of and manner st		n and/or investig	gation, in my	y opinion, death oc	curred at the time	e, date and	d place, and due to th	he cause(s)	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ February bay, 201 Year 8:30P Robert August Baxter Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 11540 Philadelphia Road Lot 7A Balto. White Marsh 7. Age (In yrs. last birthday) If Under 8. Date of Birth 9. Birthplace (State or Foreign If Under 24 Hrs. Funeral 1**X**) M 2 □ F Months Days Hours 7<sup>M</sup>3<sup>H</sup>, <sup>D</sup>F9<sup>3</sup>38 New gersey Director 089-30-6292 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location Ħ 10d. Inside City Limits Director or 28a-f s notified 1 Yes 2 No White Marsh Balto. Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ems 23a or Funeral USA 21162 11540 Philadelphia Road Lot 7A items 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, or other traumatic event, the Medical Examiner 1 Never Married 2 Married Black, White, etc. ŏ þ ☐ Yes 2 X No 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 ▼ No Specify: White Specify. Completed 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Health and Mental Hygiene. tem 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Owner- Operator Truck Driver Be Page 1 and 2 should be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Arthur Baxter Margaret Simmons 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11540 Philadelphia Road Lot 7A White Marsh, Md.21162 Sharon Baxter Spouse permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other? Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2X Cremation 3 ☐ Removal from State cemetery, crematory or other place, 2-8-2011 Balto. Md. 4 ☐ Donation 5 ☐ Other (Specify) . Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home 9705 Belair Road 21236 Nottingham, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final disease or condition resulting in death) Arrhythm Onset and Death Ph sician/ Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Completed by Physician/Medical Examiner signed by the attending physician and deed be detached for use as the burial-transi Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records,  $2 \square$  No  $3 \square$  Probably  $4 \square$  Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an after death.

Director: After this certificate has autopsy perform 2 🗆 No Yes Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: ၉ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of D + th Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural 2 No 1 Yes Accident Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined ב Puneral נ Medical 1 | Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check the only one within 7 29b. Signature and title of certifier 29c. License number ho completed cause of death (Item 23a) (Type Print) 30. Name and address of person y 32. Registr State

Registrar

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AXTER

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 11:05A M Catherino Beamon February Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Stella Maris Hospice Timonium Social Security Number If Under 1 Year If Under 24 Hrs. . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 219.42.7004 1 🗆 M 2 💢 F Days (Month, Da) Country) 65 Director Usual Residence of Decedent show 10c. City, Town or Location 10a. State 10d Inside City Limits Director Battimore Baltimore MD or 28a-f 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Falls Gable Lane, Apt. J items 23a 21209 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 within 72 hours after Specify: Black If Yes, Give Year or Dates 1 ☐ Yes 2 ☑ No Specify: Completed 3 Divorced 15. Decedent's Education 16b. Kind of Business Industry
Balthmore City 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Superument of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other trainment. Elementary/Seconday (0-12) 12+41 grade College (1-4 or 5+) Teacher Public Schools Page 1 and 2 should be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Katherine Giddins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) inda D. Simms DUSIN Lawnwood Circle Gwynn Dak, MD 21207 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Timonium, MD 2011 Dulaney Valley Cemeter 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Vaughn C. Greene Funeral Services Road Randallstown MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or he vt fa lure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ GALLBLADDER CANCER disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or finjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) in the past 12 months?

1 Yes 2 No Month Veal Day 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗶 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 ☐ Yes 2 ☐ No Yes 2 X No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital Other: 1 Yes 2 🗶 No ျပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred iniury work? 1 ☐ Yes 2 ☐ No X Natural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 JUNECIA WHITE, CRNP

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year) ... -

BARBARA BEAMON

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day YVONNE P. BROWNELLER 12:45P M **FEBRUARY** 2011 Medical 4c. County of Death
BALTIMORE 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death STELLA MARIS HOSPICE CENTER TIMONIUM Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Days 1 □ M 2 🕱 F Hours Min. 223-44-5854 79 Yrs. VIRGINIA Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Director ms 23a or 28a-f s must be notified MD BALTIMORE RASPEBURG 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 21206 U.S.A. 5606 BELLE VISTA AVENUE Funeral 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Completed by permit. Page 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injuy or other traumatic event, the Medical Examin 21215-0036 1 Yes 2 XNo Specify: 3 X Widowed 4 □ Divorced Specify: WHITE Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 10 CASHIER METRO FOOD MARKET Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) FLOYD FANTOZZI ANNA KING 19a. Informant's Name/Relationship (Type, Print)
LINDA MATHERS / DAUGHTER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  $5\,6\,0\,6$  BELLE VISTA AVE RASPEBURG, MD 21206 Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2x Cremation 3 Removal from State 4 Donation 5 Other (Specify) METRO CREMATORY 2-5-2011 CATONSVILLE, 22. Name and Address of Facility CVACH ROSEDALE FUNERAL HOME 21. Signature of Funeral Service Licenses 1211 ROSEDALE, CHESACO AVE 21237 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate nterval Between Immediate Cause (Final Onset and Death Physician/ disease or condition a. CHRONIC OBSTRUCTIVE PULMONARY DISEASE Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence on Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No Dav 4 ☐ Pregnant at time of death g ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy 2 **X** No 1 ☐ Yes 2 ☐ No Yes To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Hospital Other: 1 ☐ Yes 2 🛣 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b, Signature and the 29c. License number 29d. Date signed (Month, Day, Year) 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 JACKIE JONES, CRNP

State Registrar

p.m.

12:45

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FEBRUARY

BROWNEL LER

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Mont 165 FM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 2227 LINCOLN AVENUE SPARROWS POINT BALTIMORE 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday 8 Date of Birth 9. Birthplace (State or Foreign **Funeral** 49 Months Days Hours 9-25-1961 1 □XM 2 □ F 218-84-4894 **Director** MARYLAND Usual Residence of Decedent 28a-f show 10a. State ir than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director MD CECIL CONOWINGO 1 Yes 2 X No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 214 ROCK SPRING ROAD 21918 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. Ş 1 Never Married 2 X Married If Yes, Give Year or Dates 1 ☐ Yes 🎢 ☐ No Specify. Specify: WHITE Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 I and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) ELECTRICAL **ENGINEER** JOHNSON CONTROLS Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) CARSON **BROCKMAN** ALICE any injury or other traumatic EDER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is DEBORAH BROCKMAN/WIFE 214 ROCK SPRING ROAD CONOWINGO, 21918 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 T Cremation 3 Removal from State 4 Donation 5 Other (Specify) 2-14-2011 CATONSVILLE, METRO CREMATORY 21. Signature of Funeral Service Licensee 22. Name and Address of Facility CVACH / ROSEDALE FUNERAL HOME 1211 CHESACO AVE ROSEDALE, 21237 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as A consequence of) Examiner Sequentially list conditions, Duki to (or se a conesquence of): if any, leading to in medicause. Enter Underlying Exami Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical ohy: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months? 4 ☐ Pregnant at time of death 9 ☐ Unknown ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of autopsy page 2 No Yes 1 Yes Hospital or Attending Physician: after death.

Director: After this certific

In by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Natural
Accident
Suicide injury 5 Pending Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number

Registrar
DHMH 17 Rev 7/2009

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State

Maryland 21215-0036

Baltimore,

68760

Box

P.O.

Records,

Vital

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Division

Print)

30. Name and address of person who completed cause of death (Item 23a) (Type

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Feb. 2011 Aaron Benbow 6:05 рм Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Carroll Hospice Dove House Carroll Westminster 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Hours Min Feb. 14 1925 South Caroli Director 249-34-4930 85 Usual Residence of Decedent at of Health and Mental Hygiene. It if item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

any injury or other transmire. 10a, State 10c. City. Town or Location 10d. Inside City Limits Director Maryland Carroll Manchester 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4901 Roller Rd. 21102 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. ð 1 Never Married 2 X Married If Yes, Give 1 ☐ Yes 2 X No Specify: Specify: Black Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Baltimore County Elementary/Seconday (0-12) College (1-4 or 5+) Custodian Board of Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Prince Myer Benbow Annie Fludd 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4901 Roller Rd. Manchester, Dora M. Benbow - wife 21102 MD. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 8,2011 Feb. 1 X Burial 2 Cremation 3 Removal from State Timonium, 4 Donation 5 Other (Specify) Dulaney Valley Mem. Gardens 22. Name and Address of Facility Eckhardt Funeral Chapel P.A Signature of Funeral Service Licensee 3296 Charmil Dr. Manchester 23a. Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury been signed by the attending physician and should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death 5 Other (specify) Month Dav Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 s autopsy performed ✓ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Special 2 🛮 No 1 Yes ပ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation within 24 hours after de

To the Funeral Directo

completed filled in by th Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Ce Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. eck ly one 29b. S natu tle of certifier 29c. License numbe 29d. Date signed (Month. Dav. Year) who completed cause of death (Item 23a) (Type, Print)

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Registrar
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State

31. Date filed (Mo.

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death February Day hoone Physician/ 9:45 AM 201 reddie Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** 10 4 ecour> 2 0 > 8. Date of Birth Month, Day, 9. Birthplace (State or Foreign Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age ( **Funeral** Days Min. Tennessee 1 M 2 □ F Hours 415-36-6033 Usual Residence of Decedent Director 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at Director Baltimore 1 Fes 2 No 10f. Zin Code 10g. Citizen of What Country? 10e. Street and Number 2121 Funeral U.S.A. 105 510 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married be filed within 72 hours after Baltimore, Maryland 21215-0036 Specify: Black 1 Yes 2 No Specify. If Yes, Give Year or Dates 3 ☐ Widowed 4 ▶ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16h Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) abover Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Fatheris Name (First, Middle, Last) Page 1 and 2 should be file ment of Health and Mental ant: If item 27 is marked o ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) JOYNEY niece trina other 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other 20a. Method of Disposition Date permit. Page 1 a Department of H Important: If ite any injury or ot ■ Burial 2 □ Cremation 3 □ Removal from State 2-14-201 4 Donation 5 Other (Specify) 20 Name and Address of Facility ou Service P.A. 21. Signature of Funeral Service Licensee **√**0. oh 23a. Part 1. Enter the disease, or complications that caused the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death shock, or heart failure. List only one cause n each line Immediate Cause (Final Bilateral Mumonia Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last the attending physician a hed for use as the burial-Be Completed by Physician/Medical Box 68760 IF FEMALE: detached for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day 4 ☐ Pregnant at time of death 9 ☐ Unknown g Unknown P.O. I cate has been signed by page 2 should be detach Part J. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? nrombocy topenia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown Records, this certificate has been 24b. Were autopsy findings available 24a. Was an autopsy performed?
Yes 2 K prior to completion of cause of death?

1 
Yes 2 
No To the Hospital or Attending Physician: The I within 24 hours after death.

To the Funeral Director. After this certificate h completed filled in by the funeral director, page completed filled in by the funeral director, page 26. Place of Death (Check only one) Division of Vital 25. Was case referred to medical Hospital Other: 2 X No မ 1 Yes 1 Anpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 1 X Natural 5 Pending injury 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Ecertifying Physician. To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) 29b. Signature ebruory Medical House Officer Tess of person who completed cause of death (Item 23a) (Type, Print)

OSOYNO, 2000 West Baltimore S7 Name and ac

State Registrar Orro2()

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32. Registrar's Signature

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Maryland

Baltimore,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ February Jeanette Florence Bevard Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Gilchrist Hospice Center Towson If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. Min. Tebruary 10, 1914 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 🗆 M 2 💥 F 212-46-5834 96 Vre Director Usual Residence of Decedent J Hygiene. I other than "natural", or items 23a or 28a-f shov vent, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location the Maryland Director Baltimore Towson Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 22 Acorn Cir., #202 United States 21,286 permit. Page 1 and 2 should be filed within 72 hours after death v. Department of Health and Mental Hygleine. Important: If item 27 is marked other than "natural", or items: any injury or other traumatic event, the Medical Examiner musonce. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Armed Forces?
1 ☐ Yes 2 🗶 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes Give 1 ☐ Yes 2 X No Specify: Specify: Completed 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) own home homemaker 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Florence Mae Johnson Bradley Howard Goodman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, MD Howard Bradley Bevard/son 5205 Overcrest Ave. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Bethel Presb. Ch. Cem. Feb. 12,2011| Jarretsville, Maryland Signature of Funeral Service Licenses Mitchell Wiedereld Funeral Home, Inc. 6500 York Rd. Baltimore, MD 23a. 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Physician/ Medical resulting in death) equence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Cause (Disease or linjury that initiated events resulting in death) Last physician and s the burial-trans Due to (or as a consequence of) Be Completed by Physician/Medical law requires that the death certificate be Box 68760 38 attending IF FEMALE for use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ Live Birth 2 Live Signal Pregnant at time of death in the past 12 months? Month ☐ Yes 2 ☐ No has been signed by the a e 2 should be detached g 🗌 Unknown g Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Hrknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? funeral director, page the Hospital or Attending Physician: The I hin 24 hours after death. the Funeral Director: After this certificate h 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 400 ျှ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 1 Natural injury 5 Pending 1 ☐ Yes 2 ☐ No M Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier within 24 hou

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completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

3. Time of Death

Рм

9:35

9. Birthplace (State or Foreign

10d. Inside City Limits

1 🗆 Yes 2 📉 No

Maryland

white

21207

Approximate Interval Between Onset and Death

Day

1 ☐ Yes 2 ☐ No

21206

BALTIMORIZ

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Registrar DHMH 17 Rev 7/2009

State

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31. Date filed (Month; Day, Year)

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s of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MURIEL BERZOFSKY FEBRUARY 04 Р 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death GILCHRIST HOSPICE CARE TOWSON BALTIMORE 8. Date of Birth (Month, Day, Year) 05/05/1926 9. Birthplace (State or Foreign Country) Y If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** Min 1 □ M 2**X**□ F Months Hours 84 128-16-1749 Yrs Director Usual Residence of Decedent show 2 should be filed within 72 hours after death with the Maryland thit and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Director MD BALTIMORE TOWSON 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 800 SOUTHERLY ROAD, UNIT 217 21286 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2 X No 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: WHITE 3 X Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 WEISER **BERTHA** CARLEN WILLIAM permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1310 WOLFORD DRIVE, TRINITY, FL 34655 EDWARD DICKMAN/SON 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) 02/07/2011 REISTERSTOWN, MD OHEB SHALOM MEM.PARK : 22. Name and Address of FaciliSOL LEVINSON & BROS., INC. Signature of Funeral Service License 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ Sw disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter uncerlying Cause (Disease or linjury Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) To Be Completed by Physician/Medical 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death 9 Unknown Unknown P.O. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an performed? 2 🗌 No Yes 2 No 1 Tyes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 2 L No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Watural 5 Pending ☐ Accident ☐ Suicide ☐ Homicide Director: A Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral C

completed filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, MD 04 D71040 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NOWWOT KUMAR

DHMH 17 Rev 7/2009

State Registrar

31. Date filed (Month, Day, Year) FEB 0 9

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SUITE 4105.

BALTIMORE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2,26 Am - Month 28911 Kenneth 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Washington Medical Center Glen Burnie Anne Arundel 5. Social Security Number . Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Months Days Hours Min (Month, Day, July 03 70 219-36-2108 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 K No Maryland Anne Arundel Glan Burnie 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 111 Northdale Road 21060 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married White 1 Yes 2 No Specify: Specify 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Warehouse Manager Food Warehouse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Linzie D. Crisp Clara Alma Kinc 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gloria M. Crisp Northdale Road, Glen Burnie, MD 21060 (spouse) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Feb. 11 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Maryland Veterans Cem 2011 Crownsville, Maryland 21. Signature 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or cor shock, or heart failure. List only evebrovascular Immediate Cause (Final Onset and Death disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of)

Physician/ Medical Examiner

attending physician and for use as the burial-trar

signed by the a Id be detached f

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After this certificate

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24 hours a Funeral I

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To the Fune

the funeral director,

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Medical

Physician/

Medical

Director

Funeral

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Completed

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**Examiner** 

**Funeral** 

Director

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at

ANA 21215-0036

Maryland

Baltimore,

by Physician/Medical Completed Be ည

Certificate:

the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3
Part II. <b>Other significa</b> nt <b>condit</b> ion	s contributing to death but not resulting in	the underlying cause given in Part I

nt pregnant 2 months? No	23	c. If yes, outcome of pregni 1  Live Birth 2  Fet 4  Pregnant at time of 9  Unknown	al death 3 🔲 Ectopi	ic pregnancy (specify)		23d. Date of delivery Month Day Year
iificant conditions	cont	ributing to death but not res	sulting in the underlyin	g cause given in Part I.		o use contribute to the cause of death?  2 No 3 Probably 4 Unknown
					24a. Was an autopsy performed? 1  Yes 2	
rred to medical		/		26. Place of Death (Che	eck only one)	
No	Но	spital: 1 Inpatient 2	ER/Outpatient 3	DOA Other: 4 Nursing H	Home 5 Residence	6 Other (Specify)
5 Pending Investigat		28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury at work? 1 ☐ Yes 2 ☐ No	28d. Describe how inju	ury occurred
6 Could not determine		28e. Place of Injury - At he building, etc. (Specify		ory, office	28f. Location (Street a City or Town, Stat	nd Number or Rural Route Number, te)
				at the time, date and place,		and manner as stated.

(Check	2 Medical 3 Certifyin
29b. Signature and	title of certifie
1 Xe	orge

25. Was case referred to medical examiner?

1 Tes

27. Man r of Death

2 Accident
3 Suicide
4 Homicide

29a. Certifier

Natural

2 1 No

Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated is Nurse Pranticiner: To the best of my increased, death occurred at the time, date and place, and out the course are increased at the time, date and place, and out the course are increased.

29c. License number D41365

USD

29d. Date signed (M	onth, Day, Year)	
EEBVURVY	11 71	II
ELBRUUVY	4,20	£ 1
	. )	

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State Registrar

30. Name and address of person who completed cause of death (Ifom 23a) (Type, Print) George 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death February 5 2011 Year 9:17P Robert Bruce Cunningham 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Towson Balto. If Under 1 Year If Under 24 Hrs. 8. Date of Birth
9 125 - 1918 7. Age (In vrs. last birthday) 6. Sex 1 M 2 □ F 9. Birthplace (State or Foreign Months Days Hours Min MaryTand 92 Yrs. 705-09-8267 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Md. Balto. Nottingham 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9609 Westcott Way 21236 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. 1941-194 1 ☐ Yes 2 √ No Specify: 3 Divorced 4 Divorced Specify: White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Benefits Manager B&O Railroad 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ethel J. Smith Robert B. Cunningham 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Timonium, Md, 21093 11734 Mayfair Field Dr. R. Bruce Cunningham son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Dulaney Valley 2-10-2011 Timonium, Md. 4 ☐ Donation 5 ☐ Other (Specify) Signature of Pungal Service License Schimunek Funeral Home 22. Name and Address of Facility 9705 Belair Road Nottingham, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between

Physician/ Medical **Examiner** 

Physician/

Medical

Director

Funeral

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Completed

Be

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**Examiner** 

**Funeral** 

**Director** 

r 28a-f s notified

"natural", or items 23a o

permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medicall once."

within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

page the Funeral Director: After thin pleted filled in by the funeral

Division of Vital Records, P.O. Box 68760

To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours a To the Funeral I State

	Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a conseq		Mcar				Onset and Dea	ath
aminer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	b. Due to (or as a conseq	uence of):						
edical Exa	that initiated events resulting in death) Last	Due to (or as a conseq	uence of):						
by Physician/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnation 1 Live Birth 2 Fet 4 Pregnant at time of 9 Unknown	al death 3 🗆 Ect	opic pregnancy er (specify)		20	3d. Date of de Month	livery Day Yea	r
	Part II. Other significant conditions of	contributing to death but not res	sulting in the underl	ying cause given in Part I.				the cause of deat	
Completed					per	s an opsy formed? s 2 Ao	prior to death?	topsy findings avai completion of caus 2	
Be	25. Was case referred to medical examiner?			26. Place of Death (Ch	eck only one)				
0	1 🗆 Yes 2 🗀 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3	□ DOA Other: 4 □ Nursing	Home 5 Res	sidence 6 🖺	Other (Spec	ity) Hossai	Co
Certificate:	27. Manner of Death  1		28b. Time of injury	28c. Injury at work?  1  Yes 2 No	28d. Describe	how injury o	occurred	1	_ ,
	4 Homicide determined		ome, farm, street, fa	actory, office	28f. Location City or To	(Street and I own, State)	Number or Rui	ral Route Number,	
Medical	(Check 2   Medical Examonly one) 3   Certifying Nur	vsician: To the best of my know niner: On the basis of examinatio rse Practioner: To the best of m	n and/or investigatio	n, in my opinion, death occurre	d at the time, date	and place, a	nd due to the o	cause(s) and manne	r stated
	29b. Signature and title of certifier			29c. License number		29d. Date	signed (Month	, Day, Year)	
		A . >					1	/	

Registrar

· NCHARLES

and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Nello Cassotti Ρ <u>February</u> 2:00 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Ivy Hall Geriatric Center Middle River Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Pennsylvania 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 1 🛛 M 2 🗆 F Months Hours 204 12 3386 **Director** 85 Usual Residence of Decedent or 28a-f show notified at 10b. County 10c. City, Town or Location be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director Baltimore Maryland Middle River 1 Tes 2 No 10e. Street and Numbe 10f. Zip Code ö 10g. Citizen of What Country? ral", or items 23a o Examiner must be Funeral 123 Riverthorn Rd. 21220 USA 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No WW II Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White "natural" Completed 3 XWidowed 4 Divorced Year or Dates 1 and 2 should be filed within 72 houn of Health and Mental Hygiene. Item 27 is marked other than "natu other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Steel Worker Steel Mill 6 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Clemente Cassotti Unk. Lucia 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathleen Cassotti (Daughter) 13417 Fork Rd. Baldwin, Maryland 21013 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot 1 🗷 Burial 2 🗆 Cremation 3 🗔 Removal from State Holly Hill Mem. Gardens 2/10/2011 Baltimore, Maryland 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final disease or condition boolascu Onset and Death Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that in the cause or in the cause of th Examiner signed by the attending physician and d be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month Day Year 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performe 2**X** No 1 ☐ Yes 2 ☐ No Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 Tyes 2 🔀 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 X Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work 1  $\square$  Yes 2 🗌 No Accident Investigation 24 hours after deat Funeral Director: Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. pleted 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one 29b. Signat 29c. License numbe Name and addre

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

B 0 9 2011 Jenus S. Sacce

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 4 FEBRUARY 20<sup>Year</sup> HARRY CARL COHEN 09:45P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death MILFORD MANOR BALTIMORE BALTIMORE 6. Sex 1 M 2 D F Social Security Number **Funeral** 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Birthpia Country) MD Days Hours 0172871928 Director 220-20-4729 83 Yrs Usual Residence of Deceden items 23a or 28a-f show her must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 Tes 2 X No MD BALTIMORE BALTIMORE 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 7402 PRINCE GEORGE ROAD 21208 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Armed Forces?

1 A Yes 2 No
If Yes, Give Black, White, etc. , or Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. 3 Widowed 4 Divorced "natural" Specify: WHITE Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical lonce. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 4 PHARMACIST PHARMACY Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည HERMAN COHEN ROSE FISHER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ESTELLE COHEN / WIFE 7402 PRINCE GEORGE ROAD, BALTIMORE, MD 21208 20a. Method of Disposition
1 A Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 02/07/2011 4 Donation 5 Other (Specify) SHAAREI ZION ROSEDALE, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC . Signature of Funeral Service I 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Safer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) & obsessive Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate
cause. Enter Underlying
Cause (Disease or linjury Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): this certificate has been signed by the attending physician all director, page 2 should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 thinknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 🗌 Yes 2 40 Other: ြု 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 24 hours after death. Funeral Director: After Natural 5 Pending 1 Yes 2 No ☐ Accident ☐ Suicide Investigation completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) D31464 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. EUTAW STIME 308, BALTIMORE MD 21201 SITUALIS A. HASHMI MD. 821

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

ORIGINAL.

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Medical Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Deat 4c. County of Death N/A 9. Birthplace (State or Foreign If Under 24 Hrs. If Under 1 Year 8. Date of Birth **Funeral** Age (In vrs. last birthday) 1 🌠 M 2 🗆 F Days MAY 23, Yell 952 Months 216-58-0973 58 MARYLAND **Director** Usual Residence of Decedent 28a-f show r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Directo 1 X Yes 2 □ No MD N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6206 COPORE WAY 21224 U.S.A. 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Force Black, White, etc. \$ 1 Never Married 2 Married Yes 2X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: WHITE Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) should be filed within 72.1 and Mental Hygiene. **7 is marked other than "r** Elementary/Seconday (0-12) College (1-4 or 5+) 11 PAINTER HOME IMPROVEMENT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 HENRY WILBUR CROWLEY GEORGIA CHRISTINE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 sh nt of Health a : If item 27 is LAURA ELSAIDY/DAUGHTER 420 KANE STREET, BALTIMORE, MARYLAND 21224 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 g Department of I Important: If its any injury or of XBurial 2 Cremation 3 Removal from State OAK LAWN CEMETERY 2/7/11 BALTIMORE, MARYLAND 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses LILLY & EILER INC. FUNERAL HOME 1901 EASTERN AVENUE, BALTIMORE, MD 21231 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on earl line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying death certificate be executed sician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Dav Year Pregnant at time of death ed by the a detached f g 🗌 Unknown P.0. Part II. Other significant conditions contributing to death but no resulting in the underlying cause viven in Part I. signed I 23e. Did tobacco use contribute to the cause of death? by Flecords, Unknown 1 Yes 2 No 3 Probably 4 has been signed to a sould to Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? certificate 1 ☐ Yes 2 ☐ No 20 To the Hospital or Attending Physician: 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tyes ျ Inpatient 2 ER/Outpatient 3 DOA this Certificate: 27. Manner of Death 28a. Date of injury 4 hours after death.

uneral Director: After the fulled in by the funeral 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 2 Accident 5 Pending work? 1 🗌 Yes 2 🗌 No Investigation Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) upleted filled in by 4 Homicide determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D0059114 2 4 of death (Ite 30. Name and address of person who complete ng 23a) (Type, Print) 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Herbert Thomas	De	Constate	State	of Maryla	•	artment of rtificate of	Health ar Death	nd Menta	l Hygiene	Reg. No	201	1	0341	
Physici Medical Exami		1. Decedent's Name (First, Mi Herbert Tho		•					2. Date of D Month Februar	eath		3	3. Time of Death 0834 hrs	
e de la companya de l		4a. Facility Name (if not institu 3919 Isbell Street	tion, give	street and nu	mber)	1	b. City, Town, o			4	c. County of Montgom			
Funeral		5. Social Security Number	6. Se	×	7. Age (In yrs. i	ast birthday)	If Under 1 Ye		4Hrs. 8. Date of		/DD/YYYY)	9. Birthp	place (State or	_
Director		212-76-8967	1 X	M 2 F	50	Yrs	Months Day	ys Hours	Min. 10/	17/1	960	Foreign Coun	try) PA	
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th the Maryland 13a or 28a-f show notified at once.	Director	10e. Street and Number					10f. Zip Code				izen of What	Country	y?	
ith the 23a or		3919 Isabe	lle		et edent Ever in U.	- L.	2090			U.S				
<b>21215-0036</b> July be filed within 72 hours after death with the Maryland Mental Hygene, marked other than "natural", or Items 23a or 28a-f she revent, the Medical Examiner must be notified at once	Funeral	1 Never Married 2	Married	Armed Fo			s Decedent of Hi es, specify Cuba	spanic Origin? n, Mexican, Pu	( Specify Yes or erto Rican, etc.)	No-	14. Race - A White, 6		n Indian, Black,	
after or ral", or	by F	_		If Yes, Giva Yaar	78-82		Yes 2 X No				Specify: V	Vhit	te	
2 hours	ted	15. Decedent's Education (Specific Elementary/Secondary (0-12)		y highest grad		16a. Decedent during mo	's Usual Occupa est of working life	ition (Give kind e. DO NOT use	of work done retired)	16b.	Kind of Busin	ness/Ind	ustry	
036 ithin 7. ne. r than	Completed	Elementary coolingary (or 12	′	1	-40101)	Compu	ter Te	chnici	.an	Co	mpute	er E	Repair	
15-0 filed w Hygie d othe		17. Father's Name (First, Midd			. 7			18.Mother's N	ame (First, Middle		,			
212 212 wild be Menta market	o Be	Charles Ste		-	LI	19b. Mailing	Address (Stree		JOY B: or Rural Route N				ip Code)	_
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours af Departipent of Health and Mental Hygiene. Important: If item 27 is marked other than "natural injury or other traumatic event, the Medical Examin		20a. Method of Disposition  1 Burial 2 X Cremati	on 3 [	Removal fro	m State C	rematory or oth			Date	- 1	Location - C	•		
Itimit. Ragintment ortant:	-	4 Donation 5 Other 21. Signature Funeral Service		<del></del>	[At]		Cremat						nie, MD	_
Dem Department in jun	ļ	TSON	سر						Smith ] Street				≘ V 26726	
Physician /Medical		23a. Part I. Enter the disease, failure. List only one caus	r compli e on eac	cations that ca h line.	used the death.	Do not enter the	e mode of dying,	such as cardia	ac or respiratory a	rrest, sho	ock, or heart		Approximate Inter Between Onset a	val
Examiner		Immediate Cause (Final diseas or condition resulting in death)	_		ns of Chroni		buse						Death	
		Sequentially list conditions,	b	•		,								
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760 ficate b g physi	- CO I-	IF FEMALE: 3b. Was decedent pregnant in	the		utcome of pregn					230	d. Date of de			
Box 6876( e death certificate the attending physelfor use as the b	iciar	past 12 months?		1 Live bir 4 Pregna	τη nt at time of dea	*h - =	ildeath 3. [ er (Specify)	Ectopic pre	gnancy	1	Month	Day	Year	
	Physician/Me	1 Yes 2 No 9 U	itions	9 Unknov		sulting in the up	derlying cause g	iven in Boot I	220 Did	tabassa	use contribut	in to the	cause of death?	
P.O es that igned b	2	art ii. Odioi sigimioait cond	uone (	with ibating to	dea(() but not re	sulting in the un	denying cause g	given in Part I.		_			y 4 🗹 Unknow	n
rds,	Completed								24a. Wa	s en opsy			sy findings availat pletion of cause o	
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Division of Vital Records, P.O. tal or Attending Physician: The law requires that the safter death.  al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach.	Be	25. Was case referred to medic examiner?		spital:				of Death (Che						
of Vi ing Physi After this	2	1 Yes 2 No 27. Manner of Death		28a. Date of	f Injury	ER/Outpatient 28b. Time of Inj		y at Work?	rsing Home 5		nce 6 🗹 (	Other: So	ene	
ion (tending eath.	ation		ding estigation	(Month, C	Dey,Year)		1 🗆 Y	res 2 No						
Jor At after d I Direc	Certification:	3 Suicide 6 Cou	ild not be ermined	28e. Place	of Injury - At hor	me, farm, street,	factory, office b	uilding, etc.	28f. Location or Town,		nd Number o	r Rural I	Route Number, Ci	ty
Hospita A hour: Funera	ဋ္ဌို	4 Homicide		(Specify)	of my knowledge	death occurre	d at the time, da	te and place	and due to the car	ieo/e) an	d manner as	stated		_
Division To the Hospital or Attend within 24 hours after death To the Funeral Director:		one) 2 Medical Ex	miner: C	on the basis of nd manner sta	examination and	d/or investigatio	n, in my opinion,	, death occurre	d at the time, date	e and pla	ce, and due	to the ca	iuse(s)	
	ŽΓ	29b. Signature and title of certifi	er	2			29c. License				Date signed		Day, Year)	
	Ļ	Hamal Hamal 30. Name and address of person	1, M	moleted source	of death /lters	220	O.C.N	VI. □ .		reb	ruary 2, 2	U11 ———		
3+1		Pamela E. Southall, I	AD A	Assistant M	edical Exam	niner 900	V. Baltimore	Street, Ba	ltimore, MD 2	21223				
Sta Registi	ite ar	31. Date filed (FEBPa0 Ygr	2011	Reg	istrar's Signature	bark	1							
DHMH 17 Rev 1/20	01					ORIGINAL					DC44	c		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Anna Mary Dietz ebruarv 10:12A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Franklin Square Hospital Rosedale Balto. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year 3-24-1922 1 🗆 M 2 🛛 F Months Hours Min Country)
Maryland Director 88 213-20-8575 Usual Residence of Decedent 23a or 28a-f show 10a. State 10b. County aţ 10c. City, Town or Location 10d. Inside City Limits Director "natural", or items 23a or 28a-f sl edical Examiner must be notified 1 ☐ Yes 2 🛣 No Md. Balto. Perry Hall 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4307 Forge Road USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14 Race - American Indian Armed Forces?

1 Yes 24 No Black, White, etc. þ 1 Never Married 2 Married Yes Page 1 and 2 should be filed within 72 hours after White 1 Yes 2 No Specify: If Yes, Give 3 🔽 Widowed 4 🗌 Divorced Completed Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical II once. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Baltimore, Maryland 2121 Elementary/Seconday (0-12) College (1-4 or 5+) 8th Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Theresa Friskey John Kraft 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21087 708 Pleasant Hills Circle Kingsville, Md. Anna M. Ziomek DTR 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Joseph 2-11-2011 Fullerton, Md. Signature of Juneral Service License 22. Name and Address of Facility Schimunek Funeral Home el 9705 Belair Road Nottingham, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician disease or condition resulting in death) pama Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Liner bindenying Cause (Disease or iinjury Due to (or as a consequence of): Hospital or Attending Physician; The law requires that the death certificate be execute attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Month Year Pregnant at time of death 5 Other (specify) g Unknown been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 █ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an certificate has autopsy page 2 Yes 2X completed filled in by the funeral director, Be 25. Was case referred to medica 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ပ 1 🗌 Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this ( 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at Describe how injury occurred After 1 Natural
2X Accident iniury work? 5 Pending unknow M Investigation tebruarybizail within 24 hours after deatl To the Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4367 Forge Read Remy Hall, Mary Take 21128 Homicide Home Medical 29a. Certifier 🚅 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one 29b. Signature and title of certifie 29d. Date signed (Month. Day, Year) 1866 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) mble It: 11 CT. Lutherville litello 31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 09 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #23b.e.24a&b.25.27&29a Per Phy G912 2/0972011 Jh. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** January 20, 2011 11:07 AM Catherine Digman /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Randallstown 10404 Marriottsville Road If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In vrs. last birthdav **Funeral** Hours Months 1 ☐ M 2 🔽 F Aug 3, Director 82 220-24-3423 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a State 10b County 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Exeminer must be notified at 1 ☐ Yes 2X No Director Randallstown MD Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number USA 21133 10404 Marriottsville Rd. Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ∐Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married , or Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 🔀 No Specify. Specify: þ 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) ... wrtnin .... Mental Hygiene. r 27 is marked other than "n r traumatic even\* Elementary/Secondary (0-12) College (1-4or 5+) own home housewife 0 12 18. Mother's Name (First, Middle, Maiden Surname) unk 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item Z7 is marked oth any finity or other traumatic event once. Be William Stiehle ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10404 Marriottsville Rd; Randallstown, MD 21133 George Zumbrun - friend 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility State Anatomy Board S - N Ronald Director 655 W. Baltimore St; Baltimore, MD 21201 23a. Part of Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** a. Athena Schenosis Corne ungculo /Medical Due to (or as a consequence of): Examiner Almai Failch Sequentially list conditions, If any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): executed burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Hospital or Attending Physician: The law requires that the death certificate be Physician/Medical the as ase 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for L Month in the past 12 months? Day Year Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2XXVo 3 Probably 4 Unknown 1.5000 Completed page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? 1 Yes 2 No certificate 25. Was case referred to medical examiner? Be ( filled in by the funeral director, 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death. 2 Accident 6 □ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the Hosp within 24 hor To the Fune completely fi (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State Registrar Reglene

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31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ma

32. Registrar's Signature

20 85

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Amend Item 11 per spouse G915 5/16/11 Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician 10:10 AM 95 acl knource 01 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Har bour Herritage If Under 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 12 M 2 □ F Months Days Hours Min 266-30-608 Yrs. 82 June 16, 1938 Director Usual Residence of Decedent should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar mast be notified at 1 Yes 2 □ No Funeral Director Anne Arunde 10f. Zip Code MD 10g. Citizen of What Country? 10e. Street and Number 2140 405 Jaklund ( 12. Was Decedent Ever in U.S. Armed Forces? 1 Nes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2X Married Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. Specify <u></u> 3 ₩idewed 4 □ Divorced Black Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Hygiene. College (1-4or 5+) construction Heavy Equipment Operator 18. Mother's Name (First, Middle, Maiden Surname) UNK 17. Father's Name (First, Middle, Last) un and Mental H. Be P 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type., Print) Parker Burnie MD Z.10 20c. Location - City or Town, State Health a 21061 nole Derrick Son permit. Pages 1 and Department of Heal Important: If item 2 any injury or other 3altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) DateuwK 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Allentown, PA 4 Donation 5 ☐ Other (Specify) sceenmas) Cromator 22. Name and Address Jacility 21. Signature of uneral Service Li ITAM 1232 midvalle harch unot 23a. Part 1. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line; Approximate Interval Between Onset and Death 1/bourg Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): Box 68760, physician Physician/Medical the for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) signed by the a P.0. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed Physician: The 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? After this certifile funeral director, 26. Place of Death (Check only one) Be Hospital: Other: 1 Yes ∠ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To this 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Hospital or Attending Natural 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director; A 2 Accident the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Certifying Physi ia: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examin :: n the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one) within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of parson wh completed cause of death (Item 23a) (Type, Print) 31. Date filed (Mohth, Day, Year) 32. Registrar State FEB 09 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ FEBRUARY 01:55P M RAYMOND DABBAH 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MILFORD MANOR BALTIMORE BALTIMORE 9. Birthplace (State or Foreign Country) EGYPT Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1 🛛 M 2 🗆 F Days Min 0571871938 217-64-5355 72 Yrs. Director Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 1 X Yes 2 No N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 4014 LABYRINTH ROAD 21215 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 5 1 X Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify "natural", 3 Widowed 4 Divorced WHITE Year or Dates or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 HAIR STYLIST HAIR Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ DABBAH VICTORIA EL DABBAH MOUSSA EL19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health item 27 JOSEPH DABBAH / BROTHER 2209 SUGARCONE ROAD, BALTIMORE, MD 21209 20b. Place of Disposition (Name of ARM TINGTON OF METPERY 20a. Method of Disposition 20c. Location - City or Town, State Date Department of H Important: If ite any injury or ot 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 02/07/2011 BALTIMORE, MD CHIZUK AMUNO CONG. 21. Signature of Funeral Sprice Lice see 22. Name and Address of Facility SOL LEVINSON & BROS., INC. MD 21208 8900 REISTERSTOWN ROAD, PIKESVILLE, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one reach line. Immediate Cause (Final Onset and Death A(3 Ph sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last the burial-transit Due to (or as a consequence of): attending physician for use as the buria Physician/Medical P.O. Box 68760 IF FEMALE: signed by the attending be detached for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 ☐ Yes 2 ☐ No Yes Be ( 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☑ No Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of e Hospital or Attending P 124 hours after death. e Funeral Director: After t Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ave, Sule 203 AQVI

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Month HIRLEY -DIAMANT 05:00 A M 02 03 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** LEVINDALE HEBREW HOME BALTIMORE Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours 08/17/1919 Country Director 045-18-0340 91 CTUsual Residence of Decedent ms 23a or 28a-f show must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

ant. If item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1XXYes 2 □ No MD N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a Funeral 2434 W. BELVEDERE AVENUE 21215 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 KNo
If Yes, Give Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: 3 X Widowed 4 ☐ Divorced WHITE Year or Dates event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ RADIO COPYWRITER RADIO STATION Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ DICHTER item 27 is marke other traumatic CHARLES CELIA ROTHENBERG 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BETSY DIAMANT-COHEN/DAUGHTER 6620 CHIPPEWA DRIVE, BALTIMORE, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date permit. Page 1 a Department of H Important: If ite any injury or ot 1 XBurial 2 Cremation 3 X Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BETH EL CEMETERY 02/08/2011 STAMFORD, CT 21. Signature of uneral Service License SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death omplications Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): resulting in death) Last the attending physician hed for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FFMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown Director: After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 1 Tes 2 No filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other 2 🖵 No 1 🔲 Yes Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined To the Hospital o within 24 hours aft To the Funeral Die Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated | Medical Examiner: On the basis of examination and/or investigation, in the opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MYSICIAN 10064533 02-03-2011 LEVINDALE GERIATRIC 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2434 W. LEVINDA BELVEDENE AVENUE BALTIMORE BABATUNDE 31. Date filed (Month; Day, Year) -32. Registrar's Signature

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 4b, c per doc g911 1-4-11 vt. State of Maryland 7 Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 10:20 AM 2011 wayne 02 /Medical N/A 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Johnstopkins Bayview Care Center Baltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, **Funeral** Year) Min. Months Days Hours 1 XM 2 ☐ F 166-20-7724 31, Director 83 July 1927 Pennsylvania Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Model Even in the foundation 1 □Yes 2 →No Directo Maryland | Harford Abingdon 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 100 F Waldon Road 21009 USA within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 ▼No Specify. þ 3 ☐ Widowed 4 ☑ Divorced White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) s 1 and 2 should be filed within of Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Master Sergeant US Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Susie Sarilla Fedder Wayne Geraulum Earlston Sr. ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Peter Paul Earlston/Son 1200 Hidden Stream Ct., Abingdon, Maryland 21009 permit. Pages 1 a
Department of He.
Important: If item
any Injury or othe 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1-7-01 □ Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley Memorial Gardens Timonium, Maryland 21. Signatur of Funeral Service Licensee 22. Name and Address of Facility
McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, MD 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. iongestive Heart Failure Immediate Cause (Final **Physician** 5 years disease or condition resulting in death) /Medical Due to fir as a consequence of): Examiner Coronary Artery Disease if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Aortic Stenosis The law requires that the death certificate be executed physician and the burial-trans Due to (or as a consequence of) attending physician for use as the buria Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Year Day 4 Pregnant at time of death 5 ☐ Other (specify) P.O. I 1 ☐ Yes 2 ☐ No signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ۾ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 ☒No 24a. Was an page 2 s has autopsy certificate 1 ☐ Yes 2 X No Division of Vital Hospital or Attending Physician: director 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Skilled nuisin 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To funeral c 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death Funeral Director: the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide 29a, Certifier 🕰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D0057866 2011 MI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5505 Hopkins Bayview Medical Center Cynthia Boud 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. edent's Name (First, Middle-Last) 2. Date of Death 3. Time of Death Physician/ 19 A M Medical acility Name (if not institution, give street City, Town, or Location of Death **Examiner** 4c. County of Death 8. Date of Birth
(Month, Day, Year)
4 – 17 – 1925 If Under 24 Hrs. g. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🔀 F Days 85 Yrs. VIRGINIA Director 218-22-8092 Usual Residence of Decedent 28a-f show 10a. State 10b. County r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD BALTIMORE ROSEDALE 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8620 KELSO DRIVE **APT A208** 21237 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. "natural", or 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: WHITE Completed 3 Widowed 4 X Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) CHURCH HOME nd Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) HOSPITAL 12 CASHIER injury or other traumatic event, Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic successions. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ AMBERS COOK MARY WIEDNER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7914 BRIDGE AVENUE BEVERLY P. NELSON/DAUGHTER ROSEDALE, MD 21237 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State BEL AIR MEMORIAL 2-10-2011 4 Donation 5 Other (Specify) BEL AIR, MARYLAND Signature of Funeral Service Licensee 22. Name and Address of Facility CVACH / ROSEDALE FUNERAL HOME 1211 CHESACO AVE ROSEDALE, MD 21237 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Setweer Onset and Death m each line shock, or heart failure. List only one cay Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 ending physics of the back of yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Year Pregnant at time of death the g Unknown P.O. ed by tl signed l Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has I page 2 s autopsy perforr death? certificate 1 ☐ Yes 2 ☐ No of Vital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 🗌 Yes ည Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this funeral Manner of Death Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Day, Natural Accident nours after death.

neral Director: After a filled in by the fun 5 Pending work Division 1 Tes Investigation Could not be Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours a To the Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completed (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Date signed (Month, Day, Year) 31. Date filed (Month: Day, Year) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last)
Anthony Stephan Faulkner 2. Date of Death 3. Time of Death Year Physician/ Month 3:14 PM Januar Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Union Memorial Hospital Baltomore If Under 1 Year If Under 24 Hrs. 8, Date of Birth
Months Days Hours Min. July 1, 1960 Virginia Age (In yrs. last birthday)
50 yrs. 9. Birthplace (State or Foreign Funeral 230-88-3941 1 🔀 M 2 🗆 F Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location Director er than "natural", or items 23a or 28a-f sl the Medical Examiner must be notified MD Baltimore Yes 2 No Baltimore 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 21218 USA 1106 Bonaparte Avenue within 72 hours after death . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces?

1 Yes 2 X No
If Yes, Give 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 Specify Black 1 ☐ Yes 2 X No Specify: Completed 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Maintenance Tech. Medical 10th Be 17. Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Maiden Surname) ٥ Viola Elizabeth White Talmadge J. Faulkner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21206 6023 Saint Regis Road Baltimore, MD Betty White / Sister 20b. Place of Disposition (Name of cemetery, crematory or other place)
Union Cemetery 20a. Method of Disposition 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🔲 Removal from State 01/15/201 Charlotte CourtVA 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Dunn&Sons 5635 Eads St.NE Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Pnysician/ Brady randia 3 hours disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Asthma Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury Metastatri that initiated events the burial-tran resulting in death) Last Due to (or as a consequence of): signed by the attending physician d be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month 5 Other (specify) Pregnant at time of death 4 ☐ Pregnant : 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? After this certificate has page 2 1 Yes 2 No the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 🗌 Yes မ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural iniury 5 Pending 1 ☐ Yes 2 ☐ No Investigation Accident 24 hours after death Funeral Director: 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined City or Town, State) Medical

within 2 To the F

State Registrar 29a. Certifier

only one

29b. Signature and title of certifier

who completed cause of death (Item 23a) (Type, Print)

Registrar's Signal

Me morra

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MD.

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

AT 243894

201 East

29d. Date signed (Month, Day, Year)

201

Biltimue, 40 21218

29c. License number

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Z State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, 2. Date of Death Physician/ 41 AM Medical Facility Name (if not institution, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 8. Date of Birth (Month, Day, Year) 10/2/1960 If Under 1 If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2**X**] F Months Days Hours Min. Country)
Maryland 213-82-7190 Director 50 Usual Residence of Decedent or 28a-f show e notified at 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Director MD Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene.

Department of Health and Mental Hygiene.

The most and the most analyse of the most and the most any injury or other traumatic event, the Medical Examiner must be any injury or other traumatic event, the Medical Examiner must be. Funeral 1622 Homestead Street 21218 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. ģ 1 Never Married 2 Married 2 X No ☐ Yes Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Specify: Black Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Correctional Officer 12th Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Frank W. Valentine Willie Mae Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tyra A. Thomas (Daughter) 1622 Homestead Street, Baltimore MD 21218 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Arbutus Mem Park 2/14/2011 Balto MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Phillip A. Weatherford F.S. Signature of Funeral Service Licensee 2431 East Oliver Street, Baltimore MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on allch live. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate
Enter Underlying
Cause (Disease or iinjury Due to (or as a consequence of): use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 23d. Date of delivery 3 - Ectopic pregnancy for Month Year Pregnant at time of death 5 Other (specify) 1 Yes 2 the detached 9 Unknown cate has been signed by ; page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 No Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) nne Death 28a. Date of injury (Month, Day, Year) 88b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending Natural 1 🗌 Yes Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) and address of person who completed cause of death (Item 23a) (Type, Print) 30. Name FEB 0 9 2011 State Registrar

DHMH 17 Rev 7/2009

11-00013 Karyn Goldner-Carr Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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aryn Goldner-	Carr	State of Maryla		rtment of tificate of		Mentai H		eg. No.	1 03421
Physic		Registrar  1. Decedent's Name (First, Middle,Last)					Date of Dea    Month	ath Dav Year	3. Time of Death
ledical Exam	iner	KARYN GOLDNER  4a. Facility Name (if not institution, give street and nu		14	b. City, Town, or Le	ocation of Deat	January 1	, 2011 4c. County of Deat	0751 hrs
		6189 Londing Drive	inbor,	l'	Sykesville			Carroll	
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. la	ast birthday)	If Under 1 Year Months Days	If Under 24Hr		1Forei	thplace (State or
Director		212-60-6245 1 M 2 X F	59	Yrs.	Months Days	Hours	09/17	/1951 c	ountry)BOLIVIA
any		Usual Residence of Decedent  10a. State 10b. County	10c. City,	Town or Location	n				10d. Inside City Limits
<b>*</b>	<u> </u>	MD CARROLL	S	YKESVIL	LE				1 Yes 2 X No
Maryla 28a-f d at or	Director	10e. Street and Number	•		10f. Zip Code		1	l0g. Citizen of What Cou	ntry?
th the	E O	6189 LANDING DRIVE	edent Ever in U.	C 112 Wee	21784 Decedent of Hispa	ania Origina / S	nacify Vac or No	USA	ican Indian, Black,
ath wi	Funeral	1 Never Married 2 Married Armed Fo			s, specify Cuban, I			White, etc.	ican indian, black,
after de	by Ft	3 Widowed 4 Divorced If Yes, Give Year or Dates:		1	Yes 2X No	specify:		Specify: W	HITE
hours a	ed b	15. Decedent's Education (Specify only highest grad	- 77		s Usual Occupatio st of working life. [			16b. Kind of Business	Industry
36 hin 72 e. than "	Completed	Elementary/Secondary (0-12) College (1	-4 or 5+)	ΡΔΡΔ	LEGAL			JUDICIA	т.
5-00 led wit Hygien other	ပ္ပ	17. Father's Name (First, Middle, Last)		111101		Mother's Nam	e (First, Middle,	Maiden Surname)	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	o Be	FRANZ HILE  19a. Informant's Name/Relationship (Type, Print )	3	10h Mailing	Address (Street	KLARA	Pural Poute Nur	Smber, City or Town, State	CHLEIN
Baltimore, MD 21215-0036  permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "autural", or items 23a or 28a-f sho injury or other transmatic event, the Medical Examiner must be optified at once.	=	MAX E. HILB/BROTHER			•				21784
Te, No. 1 and 1 Health Fitem		20a. Method of Disposition  1			ion (Name of ceme		Date	20c. Location - City o	Town, State
Baltimore, permit. Pages 1 a Department of He Important: If ite injury or other ti		4 Donation 5 Other Specify:	oiii State	•		CEM. 01	/04/201	1 REISTERS	TOWN, MD
Salti ermit. Separtu mport		21. Signature of Funeral Service Licensee			me and Address o	. 5		NSON & BROS	
Physician		23a. Part I. Enter the disease, or complications that c	aused the death.	Do not enter the	OO REISTI mode of dying, so	ERSTOWN uch as cardiac	ROAD ,	PIKESVILLE, rest, shock, or heart	Approximate Interval
/Medical	5. 3	failure. List only one cause on each line.  Immediate Cause (Final disease a. Multi	ple Drus	(Oxyco	done and	Trazod	lone) In	toxication	Between Onset and Death
Examiner			consequence of		e di				
	ē		consequence of	n:					
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  C.  Due to (or as a	consequence of	f);					
50, te be executed sysician and burial - transit	Ä	d.	· ·						_
ision of Vital Records, P.O. Box 68760, Atteodiog Physiciae: The law requires that the death certificate be executed at death. rettor: Atten this certificate has been signed by the attending physician and rettor in the funeral director, page 2 should be detached for use as the bunal -transi	ledical				er me g9	12 2-4-	ll vt		
876( ifficate ng phys	cian/Me	23b. Was decedent pregnant in the	outcome of pregri		al death 3	Ectopic pregn	ancy	23d. Date of deliver Month	y Day Year
OX 6876 eath certificate attending phy for use as the t	sicia	4 Ves 2 Ma 0 University	ant at time of de	-44-	er (Specify)		70-71-17		
D. BC trthe des by the a	Phy			esulting in the ur	iderlying cause giv	en in Part I.	23e. Did to	obacco use contribute to	the cause of death?
P.C.	b						1 Ye	s 2 No 3 Pro	bably 4 Unknown
rds, requir	lete						24a. Was		utopsy findings available completion of cause of
Reco	Completed						perfo 1 ✓ Yes	ormed? death? 2 No 1 ✓ Y	es 2 No
tal Rec ciao: The certificate ector, page	Be	25. Was case referred to medical examiner?				f Death (Check			
of Vi Physical this eral direction	₽	27. Manner of Death 28a. Date	of Injury	ER/Outpatient 28b. Time of In				Residence 6  Othe	r: Scene
OD C eodiog ath. or: Af	tion	1 Natural 5 Pending (Month	Day,Year) -1-11	fd 7:40	)am 1□ Ye	s 2 🗶 No	subjec	t ingested	drugs
Division tal or Atteodi rs after death.	Certification:	3 X Suicide 6 Could not be 28e. Plac			, factory, office bui	lding, etc.	28f. Location ( or Town, 5	Street and Number or R State) 6189 Lot ville, Carro	ural Route Number, City
Divi Hospital or . 24 hours after Fuoeral Dir		4 Homicide determined (Specify)  29a. Certifier 1 Certifying Physician: To the bes	reside						
ple in the	Medical	one)	of examination ar						
To with	Me	29b. Signature and title of certifier	lateu.		29c. License	number		29d. Date signed (Mo	nth, Day, Year)
		(Caluland)			O.C.M	.E.		January 2, 2011	
World		30. Name and address of person who completed cause Laron Locke MD. Assistant Medica			timore Street	Baltimore.	MD 21223		
s	tate		gistrar's Signatu						
Regis	4	JAN U i) ZHH Zhank	A BA	4					

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

		For State Registrar	amend ite State of	m 8 per Maryland	•	artment of F rtificate of I		and Mer		iene eg. No.	1 1	1342
		1. Decedent's Name (First, Middle	, Last)					2.	Date of Dea Month		Year	3. Time of Death
Physicia /Medic		Genevieve Agn	es Gosk					Fe	bruary	7 2°,20	11	7:30A M
Examine		4a. Facility Name (If not institution	, give street and nun	nber)		4b. City, Town, or	r Location of	of Death		4c. Cour	nty of Death	
		Overlea Health					altim			1010	T a mi ii	
Funeral		5. Social Security Number	6. Sex 1 □ M 2 🔀 F	7. Age (In yrs, la	ist birthday) Yrs.	If Under 1 Year Months Days	If Under Hours	24 Hrs. 8. Min.	Date of Birth (Month, Day 11y 8	1919 1919	9. Birth	place (State or Foreign intry) y Land
Director		212-01-6106 Usual Residence of Decedent		90	113.			ρu	ily 8,	720	rial.	y Tanu
land ow		10a. State 10b. County		10c. City	Town or Lo	cation						10d. Inside City Limits
Mary Frsh	ţ	Md. B	alto.		Notti	ngham						1 □Yes 2 XNo
r 28a	Director	10e. Street and Number				10f. Zip Code			1	0g. Citizen o	of What Cou	ntry?
h with	a	9521 Perry Hal	1 Blvd.			2	1236				USA	
deat	Funeral	11. Marital Status		dent Ever in U.S	. 13.	Was Decedent of H	lispanic Ori	igin? (Specify	y Yes or No-		Race - Ameri Black, White,	
or ite		1 Never Married 2 Marri	ed 1 ☐ Yes If Yes, Giv	2 <del>□</del> No		1 □Yes 2 No	Specify:		,,	Spe		White
ural",	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Da	ites:								al desired
"nati	Completed	15. Decedent (Specify only highes	's Education t grade completed)		(Give	dent's Usual Occup kind of work done o DO NOT use retired	durina mos	t of working		16b. Kind of	Business/ir	idustry
withir ene. than	ᇍ	Elementary/Secondary (0-12)	College (1	-4or 5+)		ory Worke				Pac	kagin	g
filed Hygi other		17. Father's Name (First, Middle, I	Last)				18. Mothe	er's Name (F	First, Middle,	Maiden Surn	ame)	
ld be lental ked c	To Be	John Gosk					Ann	a Brul	linski			
shour and No man		19a. Informant's Name/Relationsh	nip (Type. Print)		19b. Mailir	ng Address (Street	and Numb	er or Rural R	oute Numbe	r, City or Tov	vn, State, Zi	ip Code)
and 2 salth a 1 27 is		Theresa Lashno	)	Sister	9521	l Perry H	a11 B	lvd.	Notti	ngham,	Md.	21236
of He fitem		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	2	20b. Pl	ace of Dispo	sition (Name of natory or other plac	ce)	Date	•	20c. Locatio	on - City or T	own, State
Pag ment ant: I		4 □ Donation 5 □ Other (S <sub>k</sub>			y Rosa	ary	2	-4-201	1 1	Dunda1	k, Md	•
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It's Medical Examinar must be notified at once.		21. Signature of Funeral Service I	iceneee		22	2. Name and Addre	ss of Facilit	<sup>ty</sup> Schi	imunek	Funer	al Ho	ne
⊈ ∪ <b>= @ ⊙</b>		Mul a	LIA			9705 Be					, Md.	21236
Physician /Medical Examiner		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions.	only one cause on early one		potic			· CD 421		SEATS	E	Approximate Interval Between Onset and Death
sate be executed physician and the burial-transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	or as a consequ								
ortificate being physici	Medical	IF FEMALE:	d								, FE	
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1 Live b	come of pregnar pirth 2 □ Fetal pant at time of de pwn	death 3[	☐ Ectopic pregnand ☐ Other <i>(specify)</i> _	÷y			23d.	Date of deli Month	very Day Year
w requires that she should be det	þ	Part II. Other significant condition	ns contributing to de	ath but not resu	lting in the u	nderlying cause giv	en in Part I	i. 		bacco use c es 2 ☐ No		the cause of death?  bbably 4 Tunknown
sician: The law r certificate has be irector, page 2 sh	Completed								24a. Was a autop perfor 1 □Yes	sv	lb. Were aut prior to c death? 1 ∐ Yes	topsy findings available completion of cause of 2  No
ician certifi ector,	Be	25. Was case referred to medical examiner?	Hospital:			Oth	or:	1	Check only or	•		
Phys	2	1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Date		ER/Outpatier 28b. Time o	nt 3 🗆 DUA	4 M		5 Resid			ify)
ding F. h. After funera	tion	1 Natural 5 ☐ Pending	(Mont	h, Day, Year)	Injury	Wor	k? Yes 2□		a. Describe ii	ow injury oo	Janea	
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	2 Accident Investig 3 Suicide 6 Could r 4 Homicide determi	ot be 28e. Place	of Injury - At hor ng, etc. <i>(Specify</i>	me, farm, str	eet, factory, office			Location (S City or Tow		ımber or Ru	ral Route Number,
he Hospita n 24 hours he Funera pletely fille	Medical C		g Physician: To the Examiner: On the ba	asis of examinat								
Vith Volume	Σ	29b. Signature and title of certifier	0			29c. Licens	se number			_		n, Day, Year)
		Lead Mary	DIE			Do	0060	560		EBR	UARY	2,2011
3			TERPAL	9106	PHIL				208	Roset	Aus	21237
Stat Registra		FEB 0 9 2011	General 32. R	egistrar's Signat	ure							

Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760-

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #30 Per ANA BD G912 (2/09/2011) All legible and Martel Hygiene

		For State Registrar		Certificate of Death	F	Reg. No	2346
hysicia	an	1. Decedent's Name (First, Middle, Last)			2. Date of Dea Month	Day Year	3. Time of Death
/Medic	al	Mary Elizabeth Grin		AL Ob. Tour of configuration of Document	January		2:39 PM
Examin	ier	4a. Facility Name (If not institution, give street as 2515 Rohrersville F	· · · · · · · · · · · · · · · · · · ·	4b. City, Town, or Location of Death Brownsville	1	4c. County of Death	
uneral		5. Social Security Number 6. Sex	7. Age (In yrs. last birth	day) If Under 1 Year   If Under 24 Hrs.	8. Date of Birth		hplace (State or For
rector		579-20-3833 1□M 2₽	89 Y	rs. Months Days Hours Min.	8. Date of Birth (Month, Day March 3	1, 1921 Ge	untry) eorgia
>		Usual Residence of Decedent	10c. City, Town				10d. Inside City Lin
shov	2	10a. State 10b. County MD Washington	2"	or Location ASVII1e			1 □Yes 2K
28a-f	ect	10e. Street and Number	DE GWI	10f. Zip Code		10g. Citizen of What Co	
la or	۵			21715		USA	ur.u.y ;
ms 2%	Funeral Director		Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert	pecify Yes or No-		
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evanther must be notified at once.	þ	1 Never Married 2 Married 1 If Ye	ed Forces? Yes 2젎No s, Give r or Dates:	If Yes, specify Cuban, Mexican, Puert 1 □Yes 2 ☑ No Specify:	o Rican, etc.)	Black, White Specify: Wh	*
ical	Completed	15. Decedent's Education		Decedent's Usual Occupation Give kind of work done during most of wor	ting	16b. Kind of Business/I	ndustry
an "r	nple	(Specify only highest grade complete Elementary/Secondary (0-12)  College   Complete   College	ege (1-4or 5+)	life. DO NOT use retired)	KING	II.G	
t th	ပ်		3	clerk		US gover	nment
d oth even	Be	17. Father's Name (First, Middle, Last)	1.4		<sub>ne (First, Middle,</sub> ell Davi	Maiden Surname)	
narke	은	Bertrum Evard Birgfe					Y = 0 = 1 = \
7 is r traun		19a. Informant's Name/Relationship (Type. Prin Sally Kreidt – daug		Malling Address <i>(Street and Number or Ru</i> 2515 Rohrersville Ro			
other	1	20a. Method of Disposition		Disposition (Name of crematory or other place)	Date	20c. Location - City or	
tant: If n jury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal 4 🛱 Donation 5 ☐ Other (Specify)	from State	i ! !	h-h- \\ \	tomy Posed	· 
any ir	0 9	21. Signature of Funeral Service Licensee		655 W. Baltimore	St; Bal		yland 212
sician edical	4 9		that caused the death. Do not on each line.	5	c or respiratory ar	rest,	Approximate Interval Between Onset and Death
miner	Examiner	Sequentially list conditions, if any leading to minimum supplementary to the sequence of the s	Habetes Mell	<i>h3</i>			yean,
mysician and the burial-tra	dical Exa	diam, leading to annuadate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last c	ue to (or as a consequence of	):			
y tne attending physician and ched for use as the burial-tra	edical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Ves. 2   Who   Ves. 2   Ves.	s, outcome of pregnancy Live birth 2 Fetal death Pregnant at time of death Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of del Month	ivery Day Year
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To the Funeral Cirector. After this certificate has been signed by the attending physician and completely filled n by the funeral director, page 2 should be detached for use as the burial-transit.	Medical Certification: To Be Completed by Physician/Medical	IF FEMALE:   23c. If ye   23c. If ye   23c. If ye   23c. If ye   23c. If ye   23c. If ye   23c. If ye   3c. If y	s, outcome of pregnancy Live birth 2   Fetal death Pregnant at time of death Unknown  g to death but not resulting in the g to death but not resulting in the Date of Injury (Month, Day, Year)  Place of Injury - At home, farm building, etc. (Specify)  To the best of my knowledge, the basis of examination and manner stated.   Physical Lause of death (Item 23a) (T	3	24a. Was a autop performent of the performance of t	Month  bacco use contribute to fes 2 No 3 Pr  an sy fried? 24b. Were au prior to death? 22 No 1 Yes  ane)  lence 6 Other (Special Control of the control of	Day Year  the cause of death obably 4 Unknown under the cause of death obably 4 Unknown of cause 2 No  cify)  ural Route Number, stated. to the cause(s)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 15:51 PM 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death NIA Security Number If Under 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 □ M 2 💢 F Months Hours Min Month, Day, Washington, D Director Usual Residence of Decedent or 28a-f show 10a. State 10c. City. Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Xes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral or items 23a death v Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces Black White, etc. þ 1 Never Married 2 Married Yes 2 Baltimore, Maryland 21215-0036 within 72 hours after "natural", If Yes, Give Year or Dates 1 Yes 2 No Specify Specify: 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) permit. Page 1 and 2 should be filled within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' College (1-4 or 5+) Elementary/Seconday (0-12) other traumatic event, Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surna) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
H202 LCGCherwcco Terrace, BurlonsvII. 19a. Informant's Name/Relationship (Type, Print, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Surial 2 Cremation 3 F 4 Donation 5 Other (Specify) Surial 2 Cremation 3 Removal from State injury or INCOLUMENOMIA! Suitland ~1-2011 22. Name and Address of Facility Signature of Wiseman Funeral Home any Alex, Ferry Rd Clinton MD2073-23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Enysician/ and Subouchnei disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of): CERTIFICATION RATECUED BY MEDICAL EXAMINER the burial-trans Due to (or as a consequence of): attending physician Physician/Medical The law requires that the death certificate be Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_ signed by the atte in the past 12 months?
1 Yes 2 No Month Year Pregnant at time of death
Unknown Day 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, Circhosis Completed 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of Diabetes 24a. Was an certificate has autonsv perform death? Yes 2 No To the Hospital or Attending Physician: completed filled in by the funeral director, Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes Hospital Other: 2 🗌 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? Natural Accide iniury 5 Pending within 24 hours after death. To the Funeral Director: A Accident Investigation 23:00 28f. Location (Street and Number or Rural Route Number, 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4202 eather would home Medical Lecrifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signat 29c. License number 27/2011 30. Name and address of perwho completed cause of death (Item 23a) (Type, Print) MU 2120 32. Registrar's Signa 31. Date filed (Month, Day, State FEB 0 9 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Jennie Grzejka 5:30 P M February 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Collingswood Nursing Center Rockville Montgomery If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Min. 1 M 2 (Month, Day, Y Hours Director 86 Oct. 198-16-1352 Pennsylvania Usual Residence of Decedent or 28a-f show notified at filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery Rockville 1 X Yes 2 No 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? ral", or items 23a or Examiner must be Funeral 522 Meadow Hall Dr. United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: White "natural", Completed 3 Widowed 4 ☐ Divorced Specify: Year or Dates r than "natur the Medical E 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) ulth and Mental Hygiene.
27 is marked other than r traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Chemical Company Clerk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) i. Page 1 and 2 should be filed timent of Health and Mental Hatant: If item 27 is marked of ပ Bukowski Josephine Orzechowski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 522 Meadow Hall Dr., Rockville, MD Margaret Grey / Daughter permit. Page 1 and 2 Department of Health Important: If Item 2: any injury or other t 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 2/8/2011 Beltsville, MD 21. Signature of Funeral Service Drense Name and Address of Facility Rapp Funeral and Cremation Services 133 Gist Ave., Silver Spring, MD 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph sician/ disease or condition resulting in death) CORONARY ARTERY DISEASE Medical Due to (or as a consequence of): Examiner ENDSTAGE RENAL DISEASE Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral inversion, page 2 should be detached for use as the burial-transi Cause (Disease or linjury DIABETES MELLITTUS eral Director: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical HYPERTENSION Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Yes 2XXNo 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 X No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 X No 1 ☐ Yes 2 ☐ No Be ( 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 4 K Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2**X** No ျှ 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1XX Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 💢 certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D41162 February 7, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 19529 Doctors Drive, Germantown, MD 20874-5262 Vinu Ganti, M.D.; 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

0 9 2011

			1 - State Registrar  1. Decedent's Nam		State of the state		- 0-	Cert	iticat	e of L	Jeatl	7	2. Date of		lo.		3. Time of Dea	
	Physicia Medi		John	Gusne	11								Month Februa		ay 76	Year	10:30A	
•	Examir		4a. Facility Name (if not institution, give street and number)  Seasons Hospice at Northwest Hospital Randallstown  4c. County of Death  Baltimore															
Funeral	7	5. Social Security Number 6. Sex 7.				yrs. last bir	rthday)		r 1 Year Days		der 24 Hrs.	8. Date of			9. Birth	place (State or Fo	reign	
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	yland f show ed at	tor	10a. State	10b. County		10	Dc. City, Tow	vn or Loca									10d. Inside City Li	
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and	be filed antal Hy ced out	To Be	17. Father's Name (i	First, Middle, Las .rd Gosne	*								e (First, Midd IcWill:		n Surname)			
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สริ	and 2 lealth em 27 ther tr		Mr. C. M 20a. Method of Disp		Gosnell	· · ·		_			ek R	<del>,                                    </del>	Fallst				01-1-	
Baltimore,	permit. Page 1 a Department of F Important: If ite any injury or ot		1 X Burial 2 I		Removal from	State	20b. Place of cemete Lake	ery, crema	atory or c	ther plac	,	į	0ate 2011		Location - 0 Sykesv	-		
Salti	permit. F Departm Importa any inju		21. Signature of Fur			L	Lake	22.	Name ar	d Addres	s of Fac	:					CHAPEL,	
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$\mathcal{F}_{\mathcal{C}}$ Division of Vital Records	Attendi r death cctor: A by the fu	Certificate:	2 Accident 3 Suicide 4 Homicide	Investigat 6  Could no	be 200 Place	of Injury -	At home, fa	arm, stree	M t, factory	1 🗆 '	Yes 2	-	28f. Location	(Street a	nd Number	or Rural	Route Number,	
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5)			30. Name and addre	palls M	completed caus 283	S Sm	(Item 23a) (	(iype, Prii Љ√ - S	-20	3,8	balt	mort	MD.	212	09.			
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	Physicia	ın/		Rosalind	L. (	Gregory		2. Date of Death Month JANUARY		Year	3. Time of Death	
	Medio Examin	al	4a. Facility Name (if not institution, give street and number	of a s	1630	City, Town, or L	ocation of Death	JANUARY	4c. County		10:18p <sup>M</sup>	
	LAAIIIII	ici	1433 TOWN WAY CT.	<i>'</i>		BALTIMO		N/		1		
-	Funeral Director		218-62-5408 1 □ M 2 🗓 F	Age (In yrs. last birth	rday) If U Mon		if Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 5-29-19	Year) 951	9. Birthp Coun MA	olace (State or Foreign try) ARYLAND	
	and show at	ē	Usual Residence of Decedent  10a. State 10b. County	10c. City, Town	or Location			-	_	1	0d. Inside City Limits	
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21215-0036 within 72 hours after death with the Maryland giene.	h the la or 3 a or 2 be no	al Di	10e. Street and Number		10f	Zip Code		1	0g. Citizen of V		ntry?	
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ဖွ	ter dez	by F	Armed Force: 1 X Never Married 2 Married 1 Yes 2	s?	If Yes,	specify Cuban,	Mexican, Puerto I	Rican, etc.)	Blac	k, White,		
003	ours af tural" al Exa		3 Widowed 4 Divorced If Yes, Give Year or Dates			s 2 💢 No				Specify: BLACK		
Maryland 21215-0036	72 hc	Completed	15. Decedent's Education (Specify only highest grade completed)		Decedent's I (Give kind of life. DO NOT	Jsual Occupati work done dur use retired)	on ring most of worki	ng	16b, Kind of Bu	usiness Industry		
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7	ould b id Mer mark matic		CHARLES GREGORY  19a. Informant's Name/Relationship (Type, Print)	19h	Mailing Add	race (Street an	SYLVIA d Number or Rura	HAWKINS		tate Zin (	Code	
$\mathbf{Z}^{g}$	d 2 shoalth ar		ANGELA HALL (DAUGHTER)				Y CT. BA					
_	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from Sta	20b. Place of cemetery		Name of or other place)		Date	20c. Location -	City or To	own, State	
ţ	t. Pagr tment rtant: njury o		4 Donation 5 Other (Specify)	KING M	EMORIA	AL PARK					MARYLAND	
Ba	permit. Page 'Department o Important: If any injury or once.		21. Signature of Funer Service Vicence JONATIA	N.D. HIBN			of Facilit <b>PHIL</b> MONROE S				P.A. LAND 21217	
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. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 ☐ Live Birt	h 2 Fetal death t at time of death					23d. Dai	te of delive	ery Day Year	
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•	<b>5</b> w it		29b. Signature and title of certifier		4/	29c. License n	y DOJ	79 25	9d. Date signed	Month, I	uay, Year)	
	Stat	0	30. Name and address of person who completed cause of the state of the	f death (Item 23a) (Ty	ype, Firint)	76	DOD O	Ed C	On V	Ry	1 170 W	
	Registra	ar	31. Date filed (Month, Day, Year) FEB 0 9 2011	N B. 19	acke	**						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 2 per doc g912 2-9-11 vt
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ FEBRUARY -6 20 Î Î 1:10 A SHIRLEY GLICK Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE GILCHRIST HOSPICE CARE TOWSON If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 🙀 F Months Days Hours Min. 2 / 29 / 1924 Yrs **Director** 213-20-2756 86 Usual Residence of Decedent 28a-f show within 72 hours after death with the Maryland Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD HARFORD PYLESVILLE ь 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 1651 HARKINS ROAD 21132 items 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 No
If Yes, Give
Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 10 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 WHITE 1 ☐ Yes 2 XNo Specify: Specify: 3 X Widowed 4 □ Divorced "natural" Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) traumatic event, the 12 CITY OF BALTIMORE **SECRETARY** Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) h and Mental I 7 is marked o ဂ pe DAVID HETTLEMAN HANNAH SKOLKIN permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LEWIS GLICK / SON 1651 HARKINS ROAD PYLESVILLE, MD 21132 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🕅 Burial 2 🗌 Cremation 3 🗌 Removal from State ARLTNGTON TO CHIZUR CO BALTIMORE, MD 02/06/2011 Donation 5 Other (Specify) CEMETERY Signature of Funcial Septice Licenses SOL LEVINSON & BROS., INC. 22. Name and Address of Facility PIKESVILLE, MD 21208 8900 REISTERSTOWN ROAD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final ance Physician/ ncreetic disease or condition resulting in death) nontas Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): sician and burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician I for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 Yes 2 No Day Year Pregnant at time of death signed by the a d be detached for Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed plnous Were autopsy findings available 24a. Was an page 2 s prior to completion of cause of death? certificate has performed? Yes 2 N 2 No 1 Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Hospital: Other: 1 Yes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence this 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No nours after death.

neral Director: After the filled in by the funeral Certificate: 28d. Describe how injury 1 Natural 5 Pending Accident Suicide М Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 24 hours a Funeral E Hospital Medical crtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only on 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated and title of certifier 29b. S/0 Patur

State Registrar 6701

istrar's Signature

Chances

me and address of person who completed cause of death (Item 23a) (Type, Print)

201

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

	for State	Certif	icate of Death	Reg. No.	
	Registrar  1. Decedent's Name (First, Middle, Last		Jan Jan Jan Jan Jan Jan Jan Jan Jan Jan	2. Date of Death	3. Time of Death
Physician /Medical	June	Harris	Tr.		ear 04:16Am
Examiner	4a. Facility Name (If not institution, give	street and number) 4b	. City, Town, or Location of Death	4c. County of	Death
	St agre		Under Tyear   If Under 24 Hrs.		Birthylage (State or Foreign
Funeral Director	231-42-1021		Under T Year If Under 24 Hrs. onths Days Hours Min.	8. Date of Birth (Month, Day, Year) 2-24-1132	Birthplace (State or Foreign Country)
land ow	Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Location	on		10d. Inside City Limits
Mary Fied a	Mb NI	A Balt	imore		1 ☐Yes 2 ☐ No
fter death with the Mar ritems 23a or 28a-f st inter must be notified Funeral Director	10e. Street and Number		Of, Zip Code	10g. Citizen of Wha	at Country?
th with with state be ust be	2208 Wal	brook Avenue	21216	U	SA
tems terms	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No	Decedent of Hispanic Origin? (Spe s, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.) 14. Race - Black,	American Indian, White, etc.
33. s s s	3 Widowed 4 □ Divorced	1	Yes 2 ☑No Specify:	Specify:	Black
21215-00 ed within 72 hou ygiene. ygiene. tr. the Medical Et. it et Medical Et. Completed	15. Decedent's Edu (Specify only highest grad	e completed) (Give kind	's Usual Occupation I of work done during most of workl	16b. Kind of Busin	ness/Industry
vithin sne.	Elementary/Secondary (0-12)	College (1-4or 5+)	NOT use retired)  Ship Build	lar Rai	Irnad
d 2 filed v Hygie other ent, III	17. Father's Name (First, Middle, Last)	Drivi	18. Mother's Name	(First, Middle, Maiden Surname)	11000
Baltimore, Maryland permit. Pages 1 and 2 should be file Department of Health and Mental Hy mportant: If item 27 is marked event any injury or other traumatic event ance. To Be (	Tune Har	ris Sr.	Hattie	Mae Joi	dan
ary shou and M s mar rumat	19a. Informant's Name/Relationship (T)	pe. Print 612 19b. Mailing A	ddress (Street and Number or Rura	al Route Number, City or Town, St	ate, Zip Code)
and 2 is lealth a m 27 is ner trau	Ms. Terrina 1	darris 1 215 N	1. toppleton	St. Balto.	MD 21201
More Pages 1 nent of H nt: If iten	20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ F	20b. Place of Disposition cemetery, cremator	n (Name of ) ry or other place)	Date 20c, Location Ci	
ti Pag treen treen ijury	4 Donation 5 ☐ Other (Specify)	Woodlaw	in Cometery 2/12	12011   Woodla	way MD
Balti permit. Departi Importa any injt	21. Signature of Fineral Service Licens	marin Lylle 23	ame and Address of Facility	funeral Home	4.1.
	23a. Part 1. Enter the disease, or comp	ications that caused the death. Do not enter the cause on each line.	ne mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between
Physician	Immediate Cause (Final	ne cause on each line.	SHAY EN	INT	Onset and Death
Physician //Medical	disease or condition resulting in death)	a. Due to (or as a consequence of):	PARC PARC	JUNE	
Examiner	8	MYOCANA	IAC INFAI	ZCTION	
it ed	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequence of):			
executed to and italiansit Examiner	that initiated events resulting in death) Last	c  Due to (or as a consequence of):			
68760, rificate be executed g physician and as the burial-transit					
6876( tificate be tig physicia as the bur		d		20-2	
		23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ed	topic pregnancy	23d. Date	
P.O. Box hat the death celd by the attendirected for use	in the past 12 months? 1 □ Yes 2 □ No		her (specify)	Mont	h Day Year
P.O. nat the de de by the etached	9 Unknown	ntributing to death but not resulting in the unde	dving cause given in Part I	23e. Did tobacco use contrib	oute to the cause of death?
HARLIES, JUNE vision of Vital Records, P.O. Box Attending Physician: The law requires that the death cer refearth. by the funeral director, page 2 should be detached for use flication: To Be Completed by Physician/A	1011 CFETTUE	Htan F FAILURE		1 □ Yes 2 □ No 3	1-4
al Record : The law requir cate has been s page 2 should I		Y 1 CAND 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		24a. Was an 24b. W	ere autopsy findings available
Rec Re law he law e has ge 2 s				autopsy pri performed? de	or to completion of cause of ath?
Vital Residuals The list certificate har rector, page $\frac{1}{2}$			26. Place of Deat	1 □Yes 2 KLiNo   1 L h (Check only one)	Yes 2 No
TARKIS  on of Vital  ing Physician: 1  After this certifica  uneral director, p	examiner?	Hospital: 1 (Inpatient 2   ER/Outpatient	Other	orne 5 Residence 6 Other	(Specify)
on ol ding Ph h. After th funeral	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury	28c. Injury at Work?	28d. Describe how injury occurred	
Sion sion tendir eath. or: A	2 Accident investigation 3 Suicide 6 Could not be		M 1 □Yes 2 □No		
Division of Vital Records, tall or Attending Physician: The law requires the after death. The certificate has been signed in by the funeral director, page 2 should be contributed by Certification: To Be Completed by	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, building, etc. (Specify)	factory, office	28f. Location (Street and Number City or Town, State)	or Hurai Houte Number,
Divisio  Divisio  To the Hospital or Attendi within 24 hours affer death. To the Funeral Director: A  completely filled in by the fu  Medical Certificati		sician: To the best of my knowledge, death or iner: On the basis of examination and/or inves and manner stated.	curred at the time, date and place, tigation, in my opinion, death occur	and due to the cause(s) and man red at the time, date and place, ar	ner as stated. nd due to the cause(s)
To the within 2 to the comple	29b. Signature and title of certifier	/ 1/	29c. License number		(Month, Day, Year)
F > F 0	12l2	The same of the sa	00061765	I FRUAM	LY 6 = 2011
		ompleted cause of death (Item 23a) (Type, Prin	nt)	FEBURNO 307 PALT. ME	
7		1A1NOO IM 3350 W	LICETS AVE 4	50/ BALT. ME	21229
State Registrar	31. Date filed (Month, Day, Year)	32. Registrar's Signature	•		

DHMH 17 Rev 1/2001

#### 11-00562 Anthony Harding

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

 . , ,				
State of Maryland	Department of	of Health	and Menta	l Hygiene

Anthony Harding		1- For State Certificate Registrar			. No.	
Physicia	ın/	Decedent's Name (First, Middle,Last)		Date of Death     Month     I	Day Year	3. Time of Death 1317 hrs
Medical Examin		Anthony Harding  4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	Month I January 20,	4c. County of Death	1317 1115
		628 North Eutaw Street # 405	Baltimore			
Funeral		5. Social Security Numberunk 6. Sex 7. Age (In yrs. last birthday		. 8. Date of Birth	(MM/DD/YYYY) 9. Birti	nplace (State or unk
Director		1⊠M 2□F 49	Yrs. Months Days Hours Min	May 30,	FUIEIGI	intry)
	ļ	Usual Residence of Decedent				10d. Inside City Limits
* a	ŀ	10a. State 10b. County 10c. City, Town or Lo				1 X Yes 2 No
Maryland 28a-f show d at once.	ģ	10e. Street and Number	10f. Zip Code	100	. Citizen of What Coun	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", ur items 23a or 28a-f shoo injury ur nither traumatite event, the Medical Examiner must be notified at once.	Director	628 N. Eutaw St #405	21217		USA	
with t			Was Decedent of Hispanic Origin? ( Sp		14. Race - Americ	can Indian, Black,
death death mr iten	Funeral	1 Yes 2 No	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	White, etc.  Specify: bla	ck
s after ral", niner	ā		Yes 2 <sup>K</sup> No specify: dent's Usual Occupation (Give kind of v	vork done		4
2 hour	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	g most of working life. DO NOT use reti	red)	Ob. Kind of Businessin	ldusu y
D36 thin 7. re. than	nple	unk unk				
5-0( led wi Hygier I other		17. Father's Name (First, Middle, Last) unk	18.Mother's Name	(First, Middle, Ma	iden Surname) unk	
21215-0036 buld be filed within 7 Mental Hygiene. marked other than ic event, the Medica	o Be	19a. Informant's Name/Relationship (Type, Print ) 19b. Ma	illing Address (Street and Number or F	Pural Pauta Numb	or City or Town State	Zin Code) 1171
MD 2 id 2 shoul lith and N m 27 is m aumatic	ř	Sheila Chester - sister	(Street and Humber of I	tarai redate reamb	or, only or rown, oute,	zip oddo, arr
e, N 1 and 3 Health item ?	ŀ	20a. Method of Disposition 20b. Place of Dis	position (Name of cemetery, rother place)	Date :	20c. Location - City or	Town, State
MOF Pages ent of nt: Li		1 Burial 2 Cremation 3 Removal from State crematory of 4 Donation 5 X Other Specify: in State	Tours place)			
Baltimore, permit. Pages 1 a Department of He Important: If ite important: If ite injury or other injury or ot	Ì	21. Signature of the relicency Licence 1/2 Director 2	2. Name and Address of Facility Sta	te Anato	omy Board	4 1 01001
		Ammy Mell	655 W. Baltimore			yland 21201 Approximate Interval
Physician Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not ent failure. List only one cause on each line.	er the mode of dying, such as cardiac o	r respiratory arres	t, snock, or neart	Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)  a Cardia Arrhythmia  Due to (or as a consequence of):				Bodin III
		Sequentially list conditions, b				
	Examiner	if any, leading to immediate cause. Enter Underlying Cause c				
H	хаш	events resulting in death) Last Due to (or as a consequence of):				
recuted		d.	012 2 2 11 +			
7 <b>60,</b> cate be executed physician and he burial - transit	Medical		me g913 3-2-11 vt		23d. Date of delivery	
1876 rtificat ing ph		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 Live birth 2	Fetal death 3 Ectopic pregna	ncy		ay Year
Box 6876 e death certifica the attending ph ed for use as the	sicia	4 Pregnant at time of death 5 Unknown 9 Unknown	Other (Specify)		l)	
Records, P.O. Box 68760,  The law requires that the death certificate be executed icate has been signed by the attending physician and page 2 should be detached for use as the burial - trans	Physician/I	Part II. Other significant conditions contributing to death but not resulting in the	he underlying cause given in Part I.	23e. Did toba	acco use contribute to t	he cause of death?
P.O. es that the igned by be detac	þ			1 Yes	2 No 3 Prob	ably 4 🗸 Unknown
rds, requir	Completed			24a. Was an		opsy findings available ompletion of cause of
eco ne law te has	d m			perform	ed? death?	
al R. III. III. III. III. III. III. III.	Be C	25. Was case referred to medical	26.Place of Death (Check			
Vita hysicia I direc	TO B	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpat			esidence 6 🗹 Other	Scene
fing P After funera		27. Manner of Death  1 X Natural 5 Panelins  28a. Date of Injury (Month, Day, Year)  28b. Time	of Injury 28c. Injury at Work?	28d. Describe ho	w injury occurred	
Sior Aftend death death by the	Cati	Pending  Accident Investigation   28e. Place of Injury - At home, farm, s		28f Location (Str	eet and Number or Rui	al Route Number City
Division of Vital Records, ral or Attending Physician: The law requir rs after death.  *I Director: After this certificate has been sted in by the funeral director, page 2 should!	Certification:	3 Suicide 6 Could not be determined (Specify)	street, factory, office building, etc.	or Town, Sta		arroate ramber, etcy
Hospit 24 hour Funer		29a. Certifying Physician: To the best of my knowledge, death or (Check only	ccurred at the time, date and place, and	due to the cause(	s) and manner as state	ed.
Division of Vital Records, P.O. B. To the Hospital or Attending Physician: The law requires that the de within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached.	Medical	one) 2 Medical Examiner: On the basis of examination and/or invest and manner stated.	tigation, in my opinion, death occurred a	t the time, date ar	nd place, and due to the	e cause(s)
	ž	29b Signature and title of certifier	29c, License number		29d. Date signed (Mon	
		(the when)	O.C.M.E.		January 21, 2011	
		30. Name and address of person who completed cause of death (Item 23a)  Laron Locke MD. Assistant Medical Examiner 900 W.	Baltimore Street, Baltimore I	MD 21223		
St	ate	31. Date filed (Month, Day, Year) 32 Registrar's Signature				
Regist		FEB 0 9 2011 Cerus B. Jac	Mal			
DHMH 17 Rev 1/20	001	ORIGII	NAL			

	1 - State Registrar	State of Maryland /	Department of Health and Certificate of Death	Reg. No.	131.37	
Physician	1. Decedent's Name (First, Middle,			Date of Death     Month Day Yea	. 1 17 17	
/Medical Examiner	4a. Facility Name (If not institution,	give street and number)	4b. City, Town, or Location of Dea	ath 4c. County of De	1	
Funeral Director	215. 40-5638	Health 4 Relations.  Sex 7. Age (In yrs. last b) 70		rs. 8. Date of Birth 9. E	Birthplace (State or Foreig	
show show	Usual Residence of Decedent  10a. State  10b. County	$\alpha$	vn or Location	•	10d. Inside City Limit	
vith the M	10e. Street and Number	Λ	10f. Zip Code	10g. Citizen of What		
within 72 hours after death with the Maryland liene. than "natural", or items 23a or 28a-f show the Macle Evarathe must be notified at ompleted by Funeral Director	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ▼No	2/228  13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pue	(Specify Yes or No- erto Rican, etc.) 14. Race - Al Black, Wi	merican Indian, hite, etc.	
ural", or all Examinates	3 ₩Widowed 4 □ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 ☑ No Specify:	Specify:	Black	
	15. Decedent's (Specify only highest :	College (1-4or 5+)	a. Decedent's Usual Occupation (Give kind of work done during most of w life. DO NOT use retired)	orking Child	Care	
be fill Hall Hall Hall Hall Hall Hall Hall H	17. Eather's Name (First, Middle, La	incoln	18. Mother's N	ame (First, Middle, Maiden Surname)		
s 1 and 2 should f Health and Men item 27 is marke other traumatic	19a. Informant's Name/Relationship	(Type. Print) 19 (Niece) 93	b. Mailing Address (Street and Number or 321 Maxwell Cour	Rural Route Number, City or Town, State  + Laure   MD	e, Zip Code) 20723	
% O L	20a. Method of Disposition  1 Burial 2 Cremation 3	☐ Removal from State	of Disposition (Name of ery, crematory or other place)	Date 20c. Location - City	or Town, State	
permit. Prage Department Important; If any Injury or once.	4 □ Donation 5 □ Other (Spe 21. Signature of Funeral Service Lie		Memorial Park 2- 22 Name and Address of Facility Vaughn, C. Greene	11-2011 Baltimor Funeral Service Vational Dike (Z	e, MD	
hysician			not enter the mode of dying, such as card	vatimal PIRE L2 iac or respiratory arrest,	Approximate Interval Between Onset and Death	
/Medical examiner	resulting in death)	Due to (or as a consequence	of):		months	
physician and is the burial-transit	Sequentially list conditions, and the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c				
se a	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No	d	h 3	23d. Date of Month	delivery Day Year	
should be detached should be detached by the should be detached by Physical letter by Physical should be physical should be sh	dua in a ser	s contributing to death but not resulting	in the underlying cause given in Part I.	23e. Did tobacco use contribute 1 ☐ Yes 2 ☐ No 3 ☐		
The law requires man the deam cate has been signed by the atter page 2 should be detached for u Completed by Physician				<ul> <li>autopsy prior performed? death</li> </ul>	autopsy findings availab to completion of cause o 1? 'es 2 □ No	
sicertification in Be	examiner?	Hospital: 1 ☐ Inpatient 2 ☐ ER/C	Other:	eath (Check only one)		
ith. :: After this e funeral d	27. Manner of Death  1 🗷 Natural 5 □ Pending 2 □ Accident investigat	28a. Date of Injury (Month, Day, Year) 28b.	Time of Injury M 28c. Injury at Work? M 1 Yes 2 No	Home 5 Residence 6 Other (Specify)  28d. Describe how injury occurred		
route roopping of Autonomy Prysician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 seminary and a feet of the funeral director, page 2 weekling the funeral directory.	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	28f. Location (Street and Number or City or Town, State)	treet and Number or Rural Route Number, n, State)			
ithin 24 hour the Funer of the Funer ompletely fill Medical			ge, death occurred at the time, date and pla ind/or investigation, in my opinion, death oc			
within To the comple	29b. Signature and title of certifier	Lehran MD	29c. License number  D 53411	29d. Date signed (Mc		
	20. Name and address of parson wh	o completed cause of death (Item 23a)		Shesadri		
	14300 Gallant	_ '	Bowle M5 20715	3.002.004.1		

DHMH 17 Rev 1/2001

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ <u>20</u>1<sup>Year</sup> Month Herman Nathanie1 Hoyte 6, February 8:30 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death 928 Mosby Dr. Frederick Frederick Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Dec 20 Birthplace (State or Foreign Country) **Funeral** Days Hours Min. 1 😾 M 2 🗆 F 120-60-5533 83 Yrs **Director** Barbados Usual Residence of Decedent 28a-f show 10a. State 10b. County Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director MD Frederick Frederick 1 Yes XX No 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 928 Mosby Dr. 21701 United States Page 1 and 2 should be filed within 72 hours after death went of Health and Mental Hygiene. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc ò by 1 Never Married 2 X Married Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Black "natural" 3 Divorced Specify: Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) is marked other than Elementary/Seconday (0-12) 1 2 College (1-4 or 5+) Custodian Paper Manufacturer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Benjamin Miller Millicent Hoyte 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. Erline Townsend / Daughter P.O. Box 3522, Frederick, MD 20a. Method of Disposition 20b. Place of Disposition (Name of Feb.Date 18. 20c. Location - City or Town, State 1XXBurial 2 Cremation 3 Removal from State cemetery, crematory or other place) 2011 Mount Olive Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Frederick, MD Rapp of Offeration Services 933 Gist Ave., Silver Spring, MD M00982 Gist Ave., Silver Spring, MD 20910 23a. Part 1. Enter the disease, nor in plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition WEAR Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or iinjury that initiated events Exami Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ 1 Live Birth
4 Pregnant
9 Unknown in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 Mo 3 ☐ Probably 4 ☐ Unknown Completed 1 Tes page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autops 1 Yes 2 No Yes funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 2 🗹 No Other: ၉ 1 Tyes 5 MResidence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending injury after death. 1 ☐ Yes 2 ☐ No Accident Investigation the 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check To the I within 2 To the I complet 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 41866 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kanan Hamed Hudhud M.D.; 46-B Thomas Johnson Dr. #200, Frederick, MD 21702 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Box 68760

P.O.

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. Nó. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 201 Physician/ Februar BLONZETTA J. HENDERSON Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner more 9. Birthplace (State or Foreign 8. Date of Birth If Under 24 Hrs. 7. Age (In yrs. last birthday) If Under 1 6. Sex Funeral 7/29/1946 VIRGINIA Months 1 M 2 F Yrs 64 234-72-9468 Director Usual Residence of Decedent 10d. Inside City Limits ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10c, City, Town or Location 10b County 10a. State Director 1 🗆 Yes 2 🛣 No TOWSON MD BALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA Funeral 21204 111 WEST ROAD Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. Armed Forces?

1 Yes 2 No
If Yes, Give 1 Never Married 2 Married þ 1 Yes 2 X No Specify: Specify: BLACK Baltimore, Maryland 21215-0036 3X Widowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) if Health and Mental Hygiene. item 27 is marked other than other traumatic event, the Me College (1-4 or 5+) Elementary/Seconday (0-12) ELECTRICIAL YEARS OFFICE CLERK Be 18, Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ ILER WALKER JOHN HOPKINS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) WOODRIGE, VA 3621 WOODHAVEN CT. RHONDA L. SERRANO/DAUGHTER 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 20a. Method of Disposition permit. Page 1 a Department of h Important: If ite 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State ROSELAWN MEM. GARDENS: 2/17/2011 PRINCETON, W VA = 5 4 ☐ Donation 5 ☐ Other (Specify) any injury once. 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, Signature of Funeral Service Licensee MO02.17 TOWSON, MD 21286 8521 LOCH RAVEN BLVD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final neumonio Physician disease or condition resulting in death) Medical Years Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that imitiated events nse wence of Examine attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) \_\_\_ Month Dav Year in the past 12 months?

1 Yes 2 No
9 Unknown been signed by the s should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No certificate 26. Place of Death (Check only one) 25. Was case referred to medica funeral director, Be examiner? 1 ☐ Yes 2 🕻 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA မှ this 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Manner of Death Certificate: (Month, Day, Year) After iniury **X** Natural 5 Pending 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: A Accident Investigation the 28f. Location (Street and Number or Rural Route Number, 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide filled in by 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed (Check within 24 only one 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0986

DHMH 17 Rev 7/2009

State Registrar 7601

Osler Drive

Name and address of person who completed cause of death (Item 23a) (Type, Print)

therin

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 9 per fb 9912 2-10-11 eath and Mental Hygiene

			for State Registrar	State of Ma		artment of Flea rtificate of Dea			IENE eg. No. 🤈 I	( ) ·	001.00	
	Physicia	n/	1. Decedent's Name (First, Middle, Las	t)		HULM	DES	2. Date of Deat	h Day	Year 1	3. Time of Death	
	Medic Examin		4a. Facility Name (if not institution, give	street and number)		4b. City, Town, or Loc		FEBRUARY	_	2011 nty of Death	10:30A M	
and a			FUTURECARE-HOMEW			BALTIN						
	Funeral Director		<u>Z14-30-3337</u>	Пмэ(ХЕІ ї	In yrs. last birthday)  Yrs.		Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, APRIL 3	Year)	Coun	olace (State or Foreign SC.	
	land show dat	ē	Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	cation				10d. Inside City Limits		
	vfaryla :8a-f s stified	rect	MD		BALTIMO	RE				1 😿 Yes 2 □ No		
	h the la or 2	al Di	10e. Street and Number			10f. Zip Code			0g. Citiz <b>e</b> n o	of What Coun	itry?	
	th wit ms 23 must	<b>Funeral Director</b>	1802 EUTAW PLACE			21217		anif . Man au Nia	US			
<u></u>	e filed within 72 hours after death with the Manyland that hygiene. ad other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at	by	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1  Yes 2  N If Yes, Give Year or Dates.	or In U.S. 13.	ecify Yes or No- Rican, etc.)		ace - Americ lack, White, e	etc.			
9500-c	hours natur dical I	olete	15. Decedent's Ed (Specify only highest gra	ducation		dent's Usual Occupation		. I	16b. Kind of	Business Inc		
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yland	ild be fil Mental narked atic ev	으	JERRY WHITE						HITE			
a	shou and is n		19a. Informant's Name/Relationship (Ty	pe, Print)	19b. Maili	ng Address (Street and	Number or Rur	al Route Number,	City or Town	, State, Zip C	lode)	
o, o	and 2 s Health tem 27		FDWARD HOLMES  20a. Method of Disposition	S/SON	20b. Place of Dispo	22 W. FAYE						
	e = = = =		1 XBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specific	Removal from State	cemetery, crei	matory or other place)	1			n - City or To		
baitimo	permit. Pa Departmer Important any injury once.	1	21. Signature of Funeral Service Licens		ARBUTUS 22	MEMORIAL P	Facility JAN	14/11   ÆS A. M	BALT I	MORE, & SONS	MD F.H., INC.	
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P	hysician/		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only or Immediate Cause (Final disease or condition	olications that caused the cause on each line.	ne death. Do not ent	er the mode of dying, su			st,		Approximate Interval Between Onset and Death	
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Ľ.	v requires that the death certificate be executed is been signed by the attending physician and should be detached for use as the burial-transit	Completed by Physician/N	Part II. Other significant conditions co				in Part I.				e cause of death?	
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<b>&gt;</b>	Physic this ce al dire	욘	1 ☐ Yes 2 → No  27. Manner of Death		2 ER/Outpatier		1	ome 5 Reside			l	
) =	ding th. After funer	cate	1 Katural 5 ☐ Pending	28a. Date of injury (Month, Day, )	'ear) 28b. Time of injury	work?	2 □ No	28d. Describe ho	w injury occu	ırred		
3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office							28f. Location (Str		ber or Rural	Route Number,		
2	ntal or urs aft ral Dir lled in			building, etc. (	,			City or Town				
	Hosp 24 hol Fune eted fil	Medical	(Check 2 Medical Examir	ner: On the basis of exam	mination and/or inves	occured at the time, dat tigation, in my opinion, d	leath occurred a	t the time, date and	d place, and	due to the cau	use(s) and manner stated.	
1	Io the within To the сотрк	Σ	only one) 3 ☐ Certifying Nurs  29b. Signature and title of certifier	e ractioner: To the be	st of my knowledge,	death occurred at the time 29c. License nur		1		manner as sta ned (Month, E		
			PH4	SICIAN		0 57	543		2-7	-11		
	5V		30. Name and address of person who co							gara		
	√ °		PREETINDER S 31. Date filed (Month, Day, Year)	ANDHU Registrar's	ND 194 Signature	OW. BALTIN	nore s	T. BAL	IMUR	6 M	72,223	
	Stat			egisti al s		00						

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 2:40 PM 201 /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner If Under 24 Hrs/ lf Under 8. Date of Birth (Month, Day, Year) 9. Birthplace Country) (State or Foreign **Funeral** Days Hours Min. Months 1 □ M 2 🗗 F **Director** Texas Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show ed other than "natural", or items 23a or 28a-f show event, the Medical Evaminer must be notified at 1 ☐ Yes 2 No Director MD Calvert Solomons 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 505 Aldersgate Court 20688 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 ∐Yes 2 M No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No þ Specify. 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event, If Item Elementary/Secondary (0-12) College (1-4or 5+) 12 Secretary Medical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jesse Byron McWhorter 2 Margaret Lucille Hudgins 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lowell B. Hinchliffe / Spouse 505 Aldersgate Court, Solomons, MD 20688 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 02/07/2011 | Hanover, Maryland 4 ☑ Donation 5 ☐ Other (Specify) Anatomy Gifts Registry 21. Signature of Juneral Servic Licensee 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** SUPRANUCLEA 1ROGRESSIVE FARI /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician: The law requires that the death certificate be executed and burial-trai Due to (or as a consequence of): Box 68760 aftending physician for use as the buris Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Vear 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No signed by the a Ö 9 🗀 Unknown 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an page 2 autopsy performed? 1 Yes 2 No certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Pesidence 6 Other (Specify) 1 ☐ Yes 2 ☐ ₩6 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident 24 hours after deat Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOH~ GEL 1201-31. Date filed (Month, Day, Year) 32. Registrar's Signature State FEB 0 9 2011 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			_ State	ate of Marylan	•	rtment of H			20	in t	01,25
			Registrar  1. Decedent's Name (First, Middle, Last)		Cer	ilicate of L	eau i	2. Date of Dea	Reg. No.		3. Time of Death
	Physicia Medi			nnie Id	da Hi	lton		Month 2	4 2 Day 20	1 <sup>Year</sup>	7:03 ам
9-1	Examir	ner	4a. Facility Name (if not institution, give street a Stella Maris	nd number)		4b. City, Town, or <b>Timor</b>	Location of Death		4c. County Bal		
	Funeral Director		5. Social Security Number   6. Sex   1 □ M 2	7. Age (In yrs. Ia	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da 8-27	th y, Year) -1935	9. Birth Coun	place (State or Foreign S . C .
	nd how at	٦	Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or Loc	ation					10d. Inside City Limits
	/arylar 8a-f s tified	Funeral Director	MD na		ltimo						1 √ Yes 2 □ No
	a or 2 be no	Ξ	10e. Street and Number	, 24	<u> </u>	10f. Zip Code			10g. Citizen of V	Vhat Cour	ntry?
	th with ms 23 must	mer	201 N. Washingto			1	21231	"	USA		
a.m.	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important; If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 Never Married 2 Married 1 If Y	as Decedent Ever in U.S ned Forces? □ Yes 2 <b>X</b> No ∕es, Give ar or Dates.		as Decedent of His Yes, specify Cubar ☐ Yes 2 <b>X</b> No		ecity Yes or No- Rican, etc.)	Blac	e - Americ k, White, Bla	
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4, faryl	hould and Me s mar umati		19a. Informant's Name/Relationship (Type, Print	t)	19b. Mailing	Address (Street a				tate, Zip (	Code)
	and 2 s Health a mm 27 i		Ricky Hilton-Son			Moravi	1		, MD 2		
FEBRUARY Baltimore,	Page 1 ament of Hant of Hant; If ite		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Remov 4 ☐ Donation 5 ☐ Other (Specify)	al from State C6	emetery, crem	ition (Name of atory or other place Cemete	9)	Date -2011	20c. Location - Balto	•	
FE Balt	permit. Depart Import any inj		21. Signature of Funeral Service Licensee	Jones		Name and Addres			h East Balto	F/H , MC	21202
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09	certificate be executed inding physician and use as the burial-transit	dical	d							$\perp$	
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O. Be	the dea	hysic		Unknown	eam 5 🗆	Other (specify)					
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H &	n: The ficate or, pag		25. Was case referred to medical				(5. 11. (0)	1 🗆 Yes		Yes	2 🗆 No
Vita	ysicia s certi directo	To Be	examiner?  1  Yes 2  No	: 1  Inpatient 2  E	ER/Outpatient	Othe	r:		lance 6 🔽 Othe	r (Specific	HOSPICE
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Divi	ital or / Irs after ral Dire		4 L Homicide determined	building, etc. (Specify)				City or Tow		r or riurar	noute Number,
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2.	Medical	29a, Certifier (Check only one) 1 Certifying Physician: To Medical Examiner: On 3 Certifying Nurse Pract	the basis of examination	and/or investig	ation, in my opinior	n, death occurred at	the time, date a	nd place, and due	to the cal	use(s) and manner stated.
	vith To th		29b. Signature and title of certifier	11,	e d	29c. License	number	200	29d. Date signed	(Month, I	Day, Year)
			30. Name and address of person who complete	d cause of dooth //ta-	220/ / 100 = 100	int)	214	14	02/6	4/	//
	MV		JUNECIA WHITE, CRN			nt) /ALLEY RD	. TIMON	IUM, MD	21093		
	Stat	e	FEB 0 9 2011	32. Redistrar's Ignatu							

DHMH 17 Rev 7/2009

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neral ector		Pineview Nursing 5. Social Security Number 6. S 577-26-9096	9x 7. A		est birthday) Yrs.	Clinton If Under 1 Year Months Days	If Under 24 F		irth ay, Yea	rince Ge	eorge's  hplace (State or Foreig untry)  nam, N.C.
CLOI	- 1-	Usual Residence of Decedent						March	2,1:	923 Dari	
To be a second s	_	10a. State 10b. County		10c. City	, Town or Lo	cation					10d. Inside City Limit 2€ Yes 2 N
	Directo	Maryland Prince Ge	eorge's	Temp	ole Hi						
į		10e. Street and Number 4419 Lyons Street				10f. Zip Code	07/0			itizen of What Co	
	runeral	11. Marital Status	12. Was Decedent	Ever in U.S	S. 13.	Was Decedent of H	0748 lispanic Origin?	(Specify Yes or N		ted Stat	rican Indian,
1	2	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces  1 Yes 2 N  If Yes, Give Year or Dates:			fYes, specify Cubi I⊡Yes 2∑XNo	Specify:	uerto Rican, etc.)		Black, Whit	
	ed	15. Decedent's Ed (Specify only highest gra	ducation		16a. Dece	ient's Usual Occup	ation	workina	16b.	Kind of Business/	Industry
	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	life.	- Admin	d)	g	CS	A - DC C	overnment
		Twelth  17. Father's Name (First, Middle, Last)	Unknown		CTELK	- Admin	18 Mother's N	Name (First, Midd			Overiment
0	200	Unknown						Pherson	o, marco	ni oumame,	
F	2	19a. Informant's Name/Relationship (	Type, Print)		19b. Mailir	g Address (Street	and Number or	Rural Route Num	ber, City	or Town, State, 2	Zip Code)
		Mayleen Jones/Dau	**			Lyons S					
		20a. Method of Disposition		00	lace of Dispo	sition (Name of natory or other place		nuary 8,	_	Location - City or	
	-	1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specifical Signature of Funeral Service Light 1)	<b>V</b> .	Line	coln M	emorial (	Cem   20	011			Maryland 1 Home Inc
X		NYKK	Donard	K. GI		661 Good	Hope R	d SE Was	naso	ton DC 2	1 Home Inc
		23a. Part1 Enter the disease, show for heart failure. List my Immediate Cause (Final disease) or condition resulting in death)			n. Do not ent		ng, such as card	diac or respiratory			Approximate Interval Between Onset and Death
al er	Je.	Sequentially list conditions,	Due to (or as	s a consequ	uence of):						
- dulmon	Yall	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as	s a consequ	ience of):						
10016	edical	(	d								
Maciolan,	Filysicianime	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a 9 Unknown	2 Fetal	death 3[	Ectopic pregnance Other (specify)	/			23d. Date of de Month	livery Day Year
i	2	Part II. Other significent conditions of	ontributing to death	but not resu	ulting in the u	nderlying cause giv	en in Part I.			o use contribute to	the cause of death?
opologo	Completed								opsy formed?	prior to death?	utopsy findings availab completion of cause of
	U	25. Was case referred to medical					26. Place of I	Death (Check onl)		10 100	20010
7		exeminer? 1 Tyes 28 No	Hospital: 1 🗌 Inpat	ient 2 🗆 I	ER/Outpatier	t 3 DOA Ott	er: 48 Nursin	g Home 5 ☐ Re	sidence	6 ☐Other (Spe	cify)
arelelonelon.		27. Manner of Death  1 ♣ Natural 5 ☐ Pending 2 ☐ Accident investigation		ury ay Year)	28b. Time o Injury	Wo	yat rk? Yes 2 ∐No	28d. Describ	e how in	jury occurred	
Corelet		3 Suicide 6 Could not b	286. Place of in	njury - At ho itc. <i>(Specify</i>	me, farm, str	eet, factory, office			(Street a		ural Route Number,
100100	ealcal	29a. Certifier 1∑ Certifying Ph (Check only one) 2 ☐ Medical Exam	niner: On the basis and manner s	of examinat	wledge, deat tion and/or in	n occurred at the til vestigation, in my o	me, date and pl ppinion, death o	ace, and due to th ccurred at the time	e cause e, date a	(s) and manner as and place, and due	s stated. e to the cause(s)
	2	29b. Signature and title of certifier	6 Cerry	-47		29c. Licens	D35206			Date signed (Mont	
		30. Name and address of person who William T. Tanner				Print) Road, F	ort Was	hington	Mary	land 207	48
State		31. Date filed (Month, Day, Year)	32. Regist	rar's Signat	ture						
istra		FEB 0 9 2011	Daneila	ß.	park						

DHMH 17 Rev 1/2001

	Ex	am
Division of Vital Records, P.O. Box 68760	Hospital or Attending Physician: The law requires that the death certificate be executed	En nous aren deau Funeral Director: After this certificate has been signed by the attending physician and

				Plea	ase Type or						•		•	e.
			For State Registrar		State	of Maryla		partment of l artificate of a		and IV	ientai Hy	/giene Reg. N	db - 5 3	001.27
	Physicia	n/	1. Decedent's Name								2. Date of De	eath	ay Year	3. Time of Death
, x	Medic Examin	al	4a. Facility Name (if		is Hance	mber)		4b. City, Town, o	or Location	of Death	Januar	y 22	2, 2011 c. County of De	8:15 PM
and.	<i>;</i>		2014 Ba	rlowe	Place			Palmer Park Prince Georg					George's	
	Funeral Director		5. Social Security No.	1071	6, Sex 1 <b>⊠</b> M 2 □ F	7. Age (In yr 7 9	s. last birthday, Yrs.	If Under 1 Year Months Days		r 24 Hrs. Min.		withplace (State or Foreign Sountry) Shington, DC		
	land show d at	tor	Usual Residence of 10a. State	10b. County		10c.	City, Town or L	ocation						10d. Inside City Limits
	r 28a-f notifie	Direc	Maryland 10e. Street and Num		e George'	S	Palmer	Park				10.0	itizen of What (	1 ☑ Yes 2 ☐ No
	s 23a c s ust be	erai	2014 Ba		Place				785			Tug. C	USA	ountry?
920	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ed by Funeral Director	11. Marital Status 1 🖾 Never Marri 3 🗌 Widowed					Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 🔀 No			cify Yes or No- Rican, etc.)	-	14. Race - An Black, Wh Specify: [	
15-0	72 hour	Completed	(Spe	15. Deceder cify only highe	nt's Education est grade completed,		16a. Dec	edent's Usual Occup kind of work done	during mos	st of workir	ng	16b. I	Kind of Busines	s Industry
21215-0036	within giene.	Con	Elementary/Second 12	onday (0-12)	College (1	-4 or 5+)	I	DO NOT use retired, ervisor	)			Fee	deral G	overnment
Maryland	uld be filed Mental Hy n <b>arked oth</b> natic event	To Be	17. Father's Name (F	S. Han	ce						(First, Middle, O. Cri		,	
Mar	d 2 shoualth and 27 is n		19a. Informant's Na Charles		nip <i>(Type, Print)</i> ck / Atto	rney		ing Address (Street Lanham S				-		
Baltimore,	Page 1 an nent of He int: If iten iry or oth		20a. Method of Disp 1 ☑ Burial 2 ☐ 4 ☐ Donation	Cremation	3 ☐ Removal from	State	cemetery, cre	osition (Name of ematory or other pla National Ce		2/11	/2011	1	ocation - City o	or Town, State Maryland
Balti	permit. I Departm Importa any inju		21. Signature of Fur	neral Service L				22. Name and Addre		•	e, P.A	47 • Hy	39 Balt	imore Avenue 1e, MD 20781
	Disposition		23a. Part 1. Enter the shock, or hear Immediate Cause (F	ne disease, or t failure. List o	complications that only one cause on ea	ach line.		_	ng, such as	cardiac o	respiratory ar	rrest,		Approximate Interval Between Onset and Death
4	Physician/ Medical Examiner		disease or condition resulting in death)		Due to	(or as a cons	equence of):	Failure						
		Examiner	Sequentially list cor if any, leading to im cause. Enter Under Cause (Disease or i	mediate iying injury	b	rtensi								
0	e be executed ysiclan and e burial-transit	lical Exa	that initiated events resulting in death) L		c. Due to	(or as a cons	equence of):							
9876	eath cerlificate be e attending physicia for use as the bur	/Med	IF FEMALE:		23c. If yes, out	toome of pred	nanov					-1		
. Box 68760	he death ce y the attenc iched for us	Physician/Medical	23b. Was decedent   in the past 12 n 1 Yes 2 2 9 Unknown	nonths?	1 Live	Birth 2 . F	etal death 3	☐ Ectopic pregnan ☐ Other (specify) _	су				23d. Date of o	elivery Day Year
ls, P.O.	requires that the de been signed by the should be detached	ed by P	Part II. Other signifi Coronar		ns contributing to dry Diseas		resulting in the	underlying cause gi	ven in Part	1.				to the cause of death?  Probably 4 🗆 Unknown
Division of Vital Records,	The law ate has bage 2	Completed by	Diabete	s Mell	itus								prior to death	utopsy findings available completion of cause of
/ital	Physician: The this certificate ral director, pag	To Be	25. Was case referre examiner?  1  Yes 2		Hospital:	Innetiont O	□ FD/0:++	Oth	lace of Dea				0	15.)
on of \	nding Phy ath. : After this e funeral d	icate: Te	27. Manner of Death  1 🔀 Natural 2 🗆 Accident		g 28a. Date (Mon		ER/Outpation  28b. Time of injury	of 28c. Injur work	y at	2	ne 5 🖎 Resi 8d. Describe i		6 Other (Sperry occurred	ccity)
Divisio	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completed filled in by the fun	Certificate:	3 ☐ Suicide 4 ☐ Homicide	6 Could determine	not be 28e. Place	of Injury - At ng, etc. (Spec		reet, factory, office		2	8f. Location (\$ City or Tov			ural Route Number,
_	he Hospit in 24 hour he Funera pleted fille	Medical	(Check 2	Medical E	Physician: To the bas xaminer: On the bas Nurse Practioner:	sis of examina	tion and/or inve	stigation, in my opini	on, death o	ccurred at	the time, date a	and place	e, and due to the	cause(s) and manner stated
	To t To t		29b. Signature and t	itle of certifler	anon,	2		29c. Licens	e number 7 603	39		29d. Da	ate signed (Mor	th, Day, Year)
(	1+1 V	İ	30. Name and addre	< HAL	who completed caus	se of death (It	em 23a) (Туре, НА,		nway	Ctr.	Dr., #31	3, Gr	eenbelt,	MD 20770
	Stat Registra	e ir	31. Date filed (Month	FEBO	9 2011 32. R	e strar s Sig	2 44	ball						
	MH 17 Pay 7/20						-							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Fe Bruces Year David M90501 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death SEASONS HOSPICE @ NORTHWEST HOSPITAL BALTIMORE RANDALLSTOWN If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country)
 DOT AND 7. Age (In vrs. last birthday) **Funeral** 04/23/1925 Director 218-16-1581 POLAND Usual Residence of Decedent or 28a-f show 10a. State 10b. County or items 23a or 28a-f sho miner must be notified at filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2X No MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 40 STIRRUP COURT 21208 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner ģ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 nours aurement of Health and Mental Hygiene.
Rant: If item 27 is marked other than "natural", 1 ☐ Yes 2 X No Specify: Specify: Completed 3 Divorced WHITE Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) 5+ PHARMACIST UNIVERSITY OF MARYLAND other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ HOFF FRANCES GRUNBLATT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LEDA HOFF/WIFE 40 STIRRUP COURT, BALTIMORE, MD 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 🖔 Burial 2 🗆 Cremation 3 🗆 Removal from State permit. Page Department of Important: If any injury or once. 4 Donation 5 Other (Specify) 02/08/2011 BALTIMORE, MD 21. Signature of Juneral Service License SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Priysician/ disease or condition Medical resulting in death) Due to (or as a onsequence of): Examiner Sequentially list conditions Examine Hospital or Attending Physician: The law requires that the death certificate be executed Renal Cause (Disease or linjury that initiated events Metastatic and Due to (or as a consequence of) resulting in death) Last attending physician ( I for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IE FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) Year Pregnant at time of death 2 No signed by the a g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown has been signed to the second Colon Cana 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate ha Prostate performed? Yes 2 2 No 1 🗌 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 1 Yes 2 No မ 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Spe After this 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide neral Director: A 1 Yes 2 No Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of D0053337 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 283 Smith

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, -Year)

State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Leo Charles Month 01 20<sup>rear</sup> Harrington 20ª/ 9:00 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Balto City 1217 West Fayette Street 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7 / 21 / 1943 9. Birthplace (State or Foreign Country)

USA **Funeral** 7. Age (In yrs. last birthday) 1 ★ M 2 □ F 219-40-2749 **Director** 67 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director MD Baltimore City 1 X Yes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral items 23a 122 N. Freemont Ave USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. of Health and Mental Hygiene.
item 27 is marked other than "natural", or iter
other traumatic event, the Medical Examiner. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 😾 No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: Specify:Black 3 Widowed 4 □ Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Pepsi Stock Clerk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked of any injury or other traumatic eve ည Leo C. Herrington Beatrice Harrington 19a. Informant's Name/Relationship (Type, Prindaughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Altheatha Harrington North Freemont Ave Balto MD 21201 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 2/9/2011 4 ☐ Donation 5 ☐ Other (Specify) Ardent Crem Hanover MD Signature of Funeral Service License 22. Name and Address of FacilityPhillip A. Weatherford FS PA 2431 E Oliver St Balto MD 21213 23a. Part 1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Cesebrovase disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Diabele that initiated events resulting in death) Last Physician/Medical Hypertensi Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 | Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Dav Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: Certificate: To 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Fractioner: To the best of my knowledge d at the time, date and clans, and due to the 29d. Date signed (Month, Day, Year) D31464 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 821 N. EUTAW ST SINTE 308 BALTMORE MD 21261 HASHMI MD 31. Date filed (Month, Day, Year) Registrar

anPleaseoType or Print in Black/Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 26 per doc g912 2-9-11 vt
State of Manyand 7 Department of Health and Mental Hydiene

			For State of Marylar  State of Marylar  Registrar	ו מי Department of ו Certificate of I			15 75 3	1 021.1.0
	Dhamini		Decedent's Name (First, Middle, Last)			2. Date of Dea		3. Time of Death
	Physicia Medi	al	NINA ROCHMAN IWRY			FEBRUA!	RY 5 201	1 01:02A M
	Examir	er	4a. Facility Name (if not institution, give street and number)	4b. City, Town, o	r Location of Death		4c. County of De	ath
	Funeral		SINAI HOSPITAL  5. Social Security Number   6. Sex   7. Age (In yrs. )	last birthday) If Under 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Birth	0.5	irthplace (State or Foreign
t e	Director		215-60-6474	94 Yrs. Months Days	Hours Will,	08/15/	11916	POLAND
	land show dat	ĕ		ty, Town or Location				10d. Inside City Limits
	Maryl 28a-f otifier	irect		ALTIMORE				1 ☐ Yes 2X No
	ith the 23a or 11 be n	<b>Funeral Director</b>	10e. Street and Number	10f. Zip Code			10g. Citizen of What (	
	eath w	-une	2401 BRAMBLETON ROAD  11. Marital Status 12. Was Decedent Ever in U.	S. 13. Was Decedent of H	lispanic Origin? (Spe	cify Yes or No-	14. Race - An	USA nerican Indian,
21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once.	by	1 ☐ Never Married 2 ☐ Married 1 ☐ Never Married 2 ☐ Married 3 ፟ Wildowed 4 ☐ Divorced  Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates.	If Yes, specify Cuba 1 ☐ Yes 2 💆 No		Rican, etc.)	Black, Wh	
15-(	72 hol n "nat Aedica	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occup (Give kind of work done of life. DO NOT use retired)	during most of workii	ng	16b. Kind of Busines	s Industry
212	within giene. er tha		Elementary/Seconday (0-12) College (1-4 or 5+) 5+	JOURNA!			JOUR	NALISM
	filed tal Hyged of other event,	To Be	17. Father's Name (First, Middle, Last)		18. Mother's Name	(First, Middle, I	Maiden Surname)	
Maryland	d Men marke matic			ROCHMAN	GUSTAVA			ANDE
	12 shc alth an 27 is r trau		19a. Informant's Name/Relationship (Type, Print)  MARK IWRY / SON	19b. Mailing Address (Street 10009 ORMON)				Zip Code)
Baltimore,	of Heal of Heal if item?	(1)		Place of Disposition (Name of		Date	20c. Location - City	or Town, State
ij	t. Page 1 attent of better the fittent of better the fittent. If its ijury or of		4 ☐ Donation 5 ☐ Other (Specify) CH	IZUK AMUNO CON	G. 02/08		BALTIMOR	
Bal	permit. Pag Departmen Important: any injury once.		21. Signature of Funeral Service Licensee	22. Name and Addre	ss of Facility SOI	LEVINS	SON & BROS	., INC.
			23a. Part 1. Ever the disease, or complications that caused the deat				PIKESVILLE est,	Approximate
3-	Physician/		shock, or heart fallure. List only one cause on each line.  Immediate Cause (Final disease or condition Atheros	osclerosis				Interval Between Onset and Death
4	Medical Examiner		resulting in death)  Due to (or as a consequ					ac years
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying b. Due to (or as a consequence.	uence of):				
	uted nd ransit	Examiner	Cause (Disease or iinjury that initiated events c					
	icate be executed physician and s the burial-transi	a E	resulting in death) Last Due to (or as a consequence of the consequence).	uence of):				
760	icate b physi s the b	ledical	d					
Box 68	aw requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregna	incy al death 3 🗌 Ectopic pregnand	CV		23d. Date of d	elivery
Bo	e deat the at hed fo	ysici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown				Month	Day Year
P.O.	that th	F P	Part II. Other significant conditions contributing to death but not res	ulting in the underlying cause given	ven in Part I.	23e. Did tol	bacco use contribute	to the cause of death?
ds,	quires en sign	Completed by	ANEMIZ			1 □ Y	es 2 No 3 🗆	Probably 4 🗆 Unknown
COL	law rei as be a 2 sho	nple	Adenocarcinoma	of Colon		24a. Was a autops	sy prior to	utopsy findings available completion of cause of
Re	n: The ficate k ir, page	S	25. Was case referred to medical		-			es 2 🗆 No
Vita	ysiciar s certil	To Be	examiner?	ER/Outpatient 3 DOA Other	er:		ence 6 🗋 Other (Spe	
of	ng Ph fter thi	E:	27. Manner of Death 1. Natural 5 □ Pending (Month, Day, Year)	28b. Time of injury work	y at 2		ow injury occurred	City)
sion	ttendi death. stor: A / the fu	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	M 1 🗆	Yes 2 No			
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the death certifi within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending completed filled in by the funeral director, page 2 should be detached for use a		building, etc. (Specify			City or Town		
	he Hosp in 24 ho he Fune	Medical	29a. Certifier (Check (Check only one)  (Certifying Physician: To the best of my knowl physician: To the basis of examination (Certifying Nurse Practioner: To the best of my	and/or investigation, in my opinio	on, death occurred at	the time, date an	d place, and due to the	cause(s) and manner stated.
	To To To To To To To To To To To To To T		29b. Signature and title of certifier	29c. License	number	2	29d. Date signed (Mon	th, Day, Year)
, T.			30. Name and address person who completed cause of death (Item	23a) (Type, Print)	0 200	1) D = 1	Dit. U	th, Day, Year) 2011 1 21209
10			1) Date filed (Month), Day, Year) 3 Registrar's Signat	MD 2700	L KITTERA	one W	Del 10' 1 le	1 21209
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M DHM	/IH 17 Rev 7/20	09						
1				ORIGINAL				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 03441 State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ EUGENE 19 30/11 Pay F. JACQUET 1425 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b City Town or Location of Death 4c. County of Death SUBURBANI HOSPITAL **BETHESDA** MONTGOMERY 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Sex 1 M 2 □ F 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours 577-58-2924 1/10/1923 Director 88 Yrs. WASTTNGTON.DC Usual Residence of Decedent ar than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director DC WASHINGTON 1 ☐XYes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral UNITED STATES 1350 CLIFTON NW #302 20009 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 ☐ Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 → No Specify If Yes, Give Year or Dates 3 Widowed 4 Divorced Specify: BLACK 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, the Mag once. College (1-4 or 5+) SECURITY GUARD PRIVATE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ALLEN HASKINS MAGNOLIA MUSKELLEY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) FANCHON HASKINS/DAUGHTER 1507 DARDEN ST HIGH POINT NC 20b. Place of Disposition (Name of cemetery, crematory or other place)
LIN. MEM. CEMETERY 2/10/11 20a. Method of Disposition 1 X Burial 2  $\square$  Cremation 3  $\square$  Removal from State 4 ☐ Donation 5 ☐ Other (Specify) SUITLAND, MD 21. Signatu e o Funeral Service 22. Name and Address of Facility CAPITOL MORTUARY icense 1425 MARYLAND AVE NE WASH 20002 23a. Part 1. Enter the disease, or complications that caused the death Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ PNEUMO MA disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of) Be Completed by Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Dav Year 1 Yes 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 N 2 **X**No 1 🗌 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manger of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Matural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 24 hours after deatle Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Yertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Cartifying Nurse Practioner: It the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and the analysis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and in amortae stated. 29b. Signature and title of certifier 29c. License number Sw, MD 10057114 1.(31111 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8600 OLD GEORGETOWN BETHESDA MD 20814 31. Date filed (Month, Day, Year) State FEB 09 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5 State of Maryland / Department of Health and Mental Hygiene 2 | | | Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death. Physician/ Month COBSEN 931 M 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Mandrin House Harwood Anne Arundel If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 225-52-7152 577-40-8315 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗷 F Days Year)938 Hours Min. June 26, Director 72 Texas Usual Residence of Decedent Show 10a. State 10b. Count within 72 hours after death with the Maryland ms 23a or 28a-f sho 10c. City, Town or Location 10d. Inside City Limits Director Annapolis 1 Yes 2 X No MD Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 2112 Chesapeake Harbor Drive East 21403 items ? n "natural", or item ledical Examiner n 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc by 1 Never Married 2 Married Maryland 21215-0036 white 1 ☐ Yes 2 X No Specify: Specify: Completed 3 X Widowed 4 Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation UNK (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 7, ment of Health and Mental Hygiene. ant: If item 27 is marked other than ury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) graphics Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Catherine Ann Knaur Winfred Clinton Hilgedick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jake Jacobsen - son 6 Carriage Run Ct; Annapolis, Maryland 21403 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Department of Important: If any injury or 4 N Donation 5 ☐ Other (Specify) permit. 22. Name and Address of Facility State Anatomy Board Sign fure comperal Service Licens rector 655 W. Baltimore St; Baltimore, Maryland 21201 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final and Death Ph\_sician/ MATUR disease or condition resulting in death) 1 Medical Due to (or s a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transi signed by the attending physician and d be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Dav Year Pregnant at time of death g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? b Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy RENA performe death? HRONIC certificate 2 No 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's MANDRIN 10 Other: 4 Nursing Home 5 Residence 1 Tes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Director: After this d in by the funeral di funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 28b. Time of 1 Natural 28d. Describe how injury occurred injury 5 Pending 2 🗆 No Investigation 6 Could not be Accident 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State, within 24 hours a

To the Funeral C

completed filled hours Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a, Certifier (Check 3 Certifying Nurse Prectioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title 🍂 Date signed (Month, Day, Year) 01 2011 leted cause of death (Item 23a) (Type, P all Morito W W 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
mend #8 Per FH G912 2/10/2011
State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ FEBRUARI 2056 M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death General Cita Maryland Hospital saltimore 5. Social Security Number . Age (In yrs. last birthday) If Under 1 Year 6. Sex If Under 24 Hrs. 8. Date of Birth Month Day, 192 **Funeral** 9. Birthplace (State or Foreign 1 🕅 M 2 🗆 F 82 Days Hours Min. Country) 20-979 Yrs **Director** Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State Director 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No 10e. Street and Number 10g. Citizen of What Country? Funeral 21244 RL 12. Was Decedent Ever in U.S. Armed Forces?

1 

Yes 2 

No If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14, Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married filed within 72 hours after 1 ☐ Yes 2 🔀 No Specify: 945 Completed 3 Widowed 4 Divorced Black Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other that amy injury or other traumatic event, the Monce. ns 02 C 01 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 018 20a. Method of Disposition 20b. Place of Disposition (Name of cernetery, crematory or other place Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2011 21. Sign Mr. of Funeral Service Licenses 22. Name and Address of F ass Service an/ 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Shoc Physician/ disease or condition resulting in death) Medical Du to (or as a consequence of) Examiner eunonia Securitally list or ditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) ascular Disease pheral Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year 2 No cate has been signed by the page 2 should be detached Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Director: After this certificate has performed? 1 ☐ Yes 2 ☐ No the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 No Other: ၉ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DCA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred ☑ Natural 5 Pending work 1 Tes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death place, and due to the cause(s) and minimal as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 3/11 HARI R BEVICOTA, MA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ) ev Kota 0:40 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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			Registrar  1. Decedent's Name (First, Middle, Last)		Cei	uncate of D	eatri	2. Da	R ate of Deat	eg. No. h		3. Time of Death
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	Examir		4a. Facility Name (if not institution, give street and number)			4b. City, Town, or				4c. Co	unty of Death	
A	Farmer's		6215 Shipview Way  5. Social Security Number # 6. Sex 7. A	ge (In yrs. las	t hirthday)	Balt If Under 1 Year			ate of Birth		0 B'4b-	
	Funeral Director		1 M 2 F	68	Yrs.	Months Days	Hours		onth, Day		Mary	lace (State or Foreign Land
	d it ow	L	Usual Residence of Decedent  10a. State 10b. County	100 City	Town or Loc	ation						
	arylan ia-f sh ified a	Director	MD Tob. County	Tuc. City,	lown or Loc		Balt	imore			10	0d. Inside City Limits  1 X Yes 2 \( \square \) No
	the M or 28	Ξ	10e. Street and Number		_	10f. Zip Code			1	0g. Citizer	of What Count	
	1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Funeral	6215 Shipview Way				1224				USA	
·0	or iter		11. Marital Status 12. Was Decedent Armed Forces 1 Never Married 2 Married 1 Yes 2 2	?	13. V	las Decedent of His Yes, specify Cuban	spanic Orig n, Mexican,	gin? (Specify Ye , Puerto Rican,	s or No- etc.)	14.	Race - America Black, White, e	
Maryland 21215-0036	ural", ural",	Completed by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates.	110	1	☐ Yes 2X No	Specify:			Spe	ecify: Bla	ck
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Z	uld be I Ment narke natic	오	Frank Jones	1								
	and 2 should be fil Health and Mental em 27 is marked ( ther traumatic eve		19a. Informant's Name/Relationship (Type, Print)  Tony Jones (Son)			g Address (Street ar Shipvie				-		,
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DIVISION OF	or Attu	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of In building, et	jury - At home tc. (Specify)	e, farm, stree	et, factory, office			cation (Stre		mber or Rural F	Route Number,
5	spital		29a. Certifier 1 Certifying Physician: To the best o	f my knowled	lge, death o	cured at the time.	date and p	lace, and due t	o the caus	e(s) and m	anner as stated	
	To the Hospital or Attending Physician: The law requires that the death certifics within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending p completed filled in by the funeral director, page 2 should be detached for use as to	Medical	(Check 2 — Medical Examiner: On the basis of only one) 3 Certifying Nurse Practioner: To the	examination a	nd/or investig	gation, in my opinion,	, death occ	curred at the tim	e, date and	place, and	due to the caus	se(s) and manner stated.
	Tot with the		29b. Signature and title of certifier	7.	$\overline{}$	29c, License r	number	7/	29	d. Date sig	gned (Month, D	ay, Year)
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			30. Name and address of person who completed cause of o	TOI	V (	hones.	Stree	+ TOL	Nan	mi	2.12	04
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Gene B. Knight		Sta	te of Maryla	and / Depa	rtment of	Health a	and l	Menta	l Hyg	giene	20	2 200	C 4 4 5
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Physician/ Medical Examine		THE (FIRST, MIDGIE	Gene	e B.K	night					Month February	7, 2011 Year		0853 hrs
			give street and nu			b. City, Town		cation of I	Death		4c. County of Baltimore		tv
5	5. Social Security	Quare Hospit	S. Sex	7. Age (In yrs. la	st birthday)	If Under 1		If Under 2	24Hrs.	8. Date of B	irth (MM/DD/YYYY)		,
Funeral Director	214-84		1X M 2 F	49	Yrs.	Months	Days	Hours	Min.		5-1961	Foreign Cour	
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	Sky	retto	omplications hat o	<u>.                                    </u>		1101	E.	Nor	th	Aven	ue Bal	to,	MD 21202 Approximate Interval
Physician /Medical	23a. Part I. Enter failure. List o	the disease, or conly one cause of	n each line.			ne mode of dy	ying, su	cri as can	ulac of i	espiratory a	rest, shock, or nea	"	Between Onset and Death
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	Sequentially list			iomegaly consequence of		Bivent	ricu	ılar	Dil	atatio	n		
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Pureral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burificial Contification: To Be Commissed by Dhysterian/Med	IF FEMALE: 23b. Was deceder	nt pregnant in the	23c. If yes,	outcome of pregr	nancy		3 [	Ectopic p		CV.	23d. Date of Month	delivery D:	av Year
x 68 h certif tending use as	past 12 mont	hs?	4 Pregi	nant at time of de	-th -	tal death her <i>(Specify)</i>	J	Letopic p	n ogriai i		, indian	5	., , , , , , , , , , , , , , , , , , ,
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Division of To the Hospital or Attending Physician 24 hours after death.  To the Funeral Director. After the Completely filled in by the funeral Completely filled in by the funeral Confiferation.	29a. Certifier 1 (Check only one) 2	☐ Certifying Ph ✓ Medical Exam	ysician: To the be niner:On the basis	of examination a	ge, death occu nd/or investiga	rred at the tim tion, in my op	ne, date inion, d	and plac leath occu	e, and d urred at	lue to the ca the time, dat	use(s) and manner te and place, and c	as state lue to the	d. cause(s)
To To To Com	29b. Signature at		and manner	stated.			cense r				29d. Date sign		
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OCME

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death 1 Decedent's Name (First Middle Last) 2 Date of Death February 4, **Physician** 201<sup>Year</sup> VIRGINIA CONSTANCE KEENE 7:00 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MANOR CARE NURSING HOME, RUXTON Towson Baltimore County If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Y Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Year Months Days Hours 1 □ M 2 🛛 F Maryland 82 1928 214-24-9196 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland r 28a-f show notified at 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐Yes 2 No Maryland Baltimore County Towson Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? an "natural", or items 23a or Medical Examiner must be r Charles Valley Court 21204 USA 8414-B Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 11 Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Completed by Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) the Secretary Medical 7 is marked other traumatic event, tl 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Walter Eugene Keene Singewald 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 an Department of Healt Important: If item 27 any Injury or other tr. once. (Nephew & PR) 708 Stoneleigh Road, Baltimore, Maryland 21212 Paul M. Aman 27 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Buriat 2 X Cremation 3 ☐ Removal from State Green Mount Crematory 2/7/2011 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signatur of Fund I Service at nue MITCHELL-WIEDEFELD FUNERAL HOME, 6500 York Road, Baltimore, Maryl HOME, INC. Maryland 21212 Martin D. Lawson 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Demention **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): burial-tran Due to (or as a consequence of) the IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Year 4□Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an performed? Yes 2 No 2 No Vital 1☐ Yes Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: 1 🖂 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) မ 0 funeral 27. Manuer of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Medical Certification: After 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 ☐ Accident within 24 hours after death To the Funeral Director; of completely filled in by the f 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

VIRBINIA

Keene

31. Date filed (Month, Day, Year)

505 HIMMIN FEB 0 9 2011

30. Name and add ss of person who completed cause of death (Item 23a) (Type, Print)



DHMH 17 Rev 1/2001

Drive TOWSON,

112-04-11

21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Audrey Denise La	-	y-ragan State of Maryland / Department of Health and Me 1-For State Certificate of Death	ental Hygien	e Reg.	2011	0344
Physicia Medical Examin		1. Decedent's Name (First, Middle, Last)  AUDREY DENICE LATTY - FAGAN	Mont	of Death	ay Year	3. Time of Death 2315 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location 13031 Victoria Heights Drive Bowie		uary Z,	4c. County of Dea	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 1 Yea		e of Birth (I	MM/DD/YYYY) 9. B	irthplace (State or
Director		S 77 - 04 - 62 06 1 M 2 F 65 Yrs. Months Days Ho Usual Residence of Decedent	ours Min. 0	1.14	· 1946 C	ountry) JAMAICA
w any		10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
aryland Ba-f sho	Director	MD PRINCE GEORGES BOWIE  10e. Street and Number  10f. Zip Code		10a.	Citizen of What Cou	1 X Yes 2 No
th the M  23a or 2		13031 VICTORIA HEIGHTS DR 2071S  11. Marital Status  12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic C	5		JAMAICA	
death with the Maryland or items 23s or 28s-f show	Funeral	11. Marital Status  1 Never Married	Origin? (Specify Ye	s or No-		rican Indian, Black,
rs after of	اھ	3 Widowed 4 Divorced If Yes, Give Year or Dates:  15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Given Specify only highest grade completed) 16a. Decedent's Usual Occupation (Given Specify only highest grade completed)	-	1	Specify: BL	
6 172 hou an "nath	eted	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. DO NO	OT use retired)	16	b. Kind of Business	,
21215-0036 uld be filed within 7. Mental Hygiene. are other than c event, the Medical	Completed	12 5 <sup>+</sup> Bysiness 01	WNER ner's Name (First, M	liddle, Maid	PRIVA	TE
ID 21215-00; should be filed withing and Mental Hygiene. The marked other II matic event, the Med	Be	LESTER LAWSO N LATTY  19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and No	AISIE .	AGAT	HA BUR	TON
<b>○</b> 성 전 := # .	٩	CLAUDIA LATTY - BAILEY STER /303 / VICTORIA 200. Method of Disposition (Name of cemetery,	HEIGHTS D	R Bo	, City or Town, State	20715
Baltimore, MI permit. Pages 1 and 2 a Department of Health a Important: It item 27 injury or other traum.		1   Burial 2   X Cremation 3   Removal from State   Crematory or other place)	1			
altim rmit. Pa partmen portant iury or	- 1	4 Donation 5 Other Specify: CHESA PEAKE  21. Signature of Funeral Service Licensee  22. Name and Address of Faci	0 <i>2 · / o · a</i>	1425	MARYLAN	LÉ, MD D AVÉ NÉ
Physician	1	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as	TUARY Y	VASH II	HGTON DO	20002 Approximate Interval
/Moical Examiner	1	Immediate Cause (Final disease  a. Hypertensive Atherosclerotic Cardiovascular Disease	,,,,,,	,		Between Onset and Death
		or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions,  b.				
	Examiner	if any, leading to immediate Cause. Enter Underlying Cause (Disease or injury that initiated Cause Cau				
nted nd ransit		events resulting in death). Last Due to (or as a consequence of):	-			
68760, certificate be executed nding physician and se as the burial - transit	redical -	UNPENDED AMENDED				
OX 6876 eath certificat eath certificat eath certificat for use as the		past 12 months?	pic pregnancy		23d. Date of deliver Month	/ Day Year
the death certification by the attending placed for use as the che	nysic	1 Yes 2 ✓ No 9 Unknown Pregnant at time of death 5 Other (Specify) 9 Unknown		_		
ires that the signed by I be detach		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in F Diabetes mellitus		_	O use contribute to	the cause of death?
Records, P.( The law requires tha ficate has been signed ; page 2 should be det				Was an autopsy	24b. Were au	topsy findings available
tal Reco				performed Yes 2	? death?	_
of Vital Records, or Physician: The law require there this certificate has been sineral director, page 2 should be a feed of the Commission of To Re Commission.	ŏ١	25. Was case referred to medical examiner?  1  Yes 2 No  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA  Other 1	h (Check only one)  Nursing Home	5 Resi	dence 6 🗸 Other	: Scene
on of or of the state of the st	3	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Wor 1 Natural 5 Pending 1 Yes 2		cribe how i	njury occurred	
Division c spital or Attending rours after death. neral Director: Aft filled in by the func		2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, 6	etc. 28f. Loca			ral Route Number, City
		4 Homicide determined (Specify)  29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and p		own, State)		
To the Hospital within 24 hours To the Funeral completely filled		one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death o and manner stated.	occurred at the time,	date and p	and manner as state place, and due to the	ed. e cause(s)
2		29b Signature and title of certifier  29c. License number  O.C.M.E.	er	1	d. Date signed (Morebruary 4, 2011	oth, Day, Year)
	3	30. Name and address of person who completed cause of death (Item 23a)	D-10			
State	e 3	Donna M. Vincenti, MD Assistant Medical Examiner 900 W. Baltimore Street  31. Date filed (Month, Day, Year) 32 Registrar's Signature	, Baltimore, MI	21223 <i>د</i>		
Registra	٥Į_	FEB 0 9 2011 Lenus S. Janes				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend19b Per PHY G912 2/09/2011 JH

State of Maryland / Department of Health and Mental Hygiene State of Maryland / Department of Health and Mental Hygiene Registrar

For Amend items 1, per doc, 20a-c, 22 per fh g912 2-22-11 vt

Registrar

Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Bamikole** 01aniyan **Physician** Month 20 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death Examiner Health+ Reha Itimore Baltimore Mal If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** M 2□F Months Days 116809671 39 Director Nov 26, 1971 New York Usual Residence of Decedent r 28a-f show notified at 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Director 1 ☐ Yes 2 ☑ No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or 21207 USA 4017 Liberty Heights Avenue Funeral r than "natural", or items the Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or ite any injury or other traumatic event, the Medical Examine. 1 ☐ Yes 2 ☒ If Yes, Give Year or Dates: 2 X No 1 Never Married 2 Married black Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) customer service fast food industry 18. Mother's Name (First, Middle, Maiden Surname) unk 17. Father's Name (First, Middle, Last) Be Bamikole Laniyan Sr. ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)unk 9005A N. Laurel, Maryland 20723 Festus Akindele Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State **IX** Burial 2 ☐ Cremation 3 ☐Removal from State 4 □ Donation 5 IN Other (6 Zion 2-11-11 Baltimore, Md. 22 Name and Address of Facility State 4300 Robert S. Wade Anatomy Board Wabash Ave ; Baltimore, Ma 21215 Maryland 21201 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine be executed burial-tran Due to (or as a consequence of): Box 68760 attending physician Physician/Medical the for use as IF FEMALE: If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4□Pregnant at time of death 5 ☐ Other (specify) P.0. been signed by the a should be detached 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying of 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 Yes 2 No 3 Probably Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performe 1 ☐ Yes 2 ☐ No 1□ Yes & No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes €XNo 2 1 ☐ Innatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Hospital or Attending 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No death 24 hours after death Funeral Director: filled in by the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier npletely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 24 29d. Date signed (Month, Day, Year) 29b. Signature and title of pertifie 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ano 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 02 Month VINCENT FRANK LANASA 02 2011 :30 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City Town, or Location of Death 4c. County of Death <u>Baltimore Washington Medical</u> Burnie Anne Arundel 8. Date of Birth **Funeral** . Age (In vrs. last birthday) Birthplace (State or Foreign Country) 0 2 2 3 1 1 **⊠** M 2 □ F Months Days Hours Min 30 6148 Director 76 MD Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director MD Anne Arundel Pasadena 1 Yes 2 No 10e. Street and Number 23a or 10f. Zip Code 10g, Citizen of What Country? Funeral 8452 Greenway\_Road items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. ō ģ 1 Never Married 2 Married 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural", 3 Widowed 4 Divorced Specify: Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Planner/Inspector Bethlehem Steel f Health and Mental Hygie item 27 is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Vincent Michael Lanasa Mary Sansone 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Lanasa - Wife 8452 Greenway Rd Pasadena, MD 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a Department of H Important: If ite 20c. Location - City or Town, State cemetery, crematory or other place) injury or 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) <u>Haven Mem Pk 2/8/2011</u> Glen Burnie, MD 22. Name and Address of Facility GJ Gonce Funeral 21. Signature of Fane I Service Licensee Riviera Drive <u>Pasadena</u>, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ nonar **Medical** Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last the burial-trar Due to (or as a consequence of) signed by the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown . Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an page 2 s this certificate has autopsy Yes completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 1 🗌 Yes 2 No Other 1 🗌 Inpatient 2 🌌 ER/Outpatient 3 🗌 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at To the Hospital or Attending F within 24 hours after death.
To the Funeral Director: After i 28d. Describe how injury occurred Natural 5 Pending 1 🗌 Yes 2 No Accident Investigation Suicide 6 Could not be 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 00485 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Ear Mirza Nusairee, MD 301 Hospital Drive Glen Burnie, MD 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month O Z DnieR 201 2000 M 10 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince George's Southern Maryland Hospital Clinton 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) MD **Funeral** 8. Date of Birth 1 ▼ M 2 □ F Hours Min. 03-22-1939 579-52-2472 **Director** Usual Residence of Decedent 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho, any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Prince George's Clinton 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8403 Schultz Road USA 20735 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 □ No
If Yes, Give
Year or Dates, 1962 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 - Widowed 4 - Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Deputy Sheriff (Captain) PG County Sheriff Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Ethel L. Hinton Emmett M. Lanier 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gail A. Lanier/wife 8403 Schultz Rd.,Clinton, MD 20735 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Cedar Hill Cem. 20a. Method of Disposition 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 02-07-201 Suitland, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 20746 22. Name and Address of Facility L Cedar Hill FH,4111 PA Ave., Suitland, 715/4 Reid MO1616 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final epsis Physician/ disease or condition 4 hv Medical resulting in death) Due to (or consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner a Consequence on attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month Day Year g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ardio m Completed 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy certificate 1 ☐ Yes 2 ☐ No Yes 2 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 1 🗌 Yes 2 No Other 1 Inpatient 2 ER/Outpatient 3 DOA this 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) I Director: After to d in by the funera 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending iniury work? 1 ☐ Yes 2 ☐ No Accident Investigation 2 ☐ Accident
3 ☐ Suicide
4 ☐ Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined within 24 hours after

To the Funeral Direct

completed filled in b Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier icense numbe 29d. Date signed (Month, Day, Year) DKI ohn 201

Registrar

State

30. Name and address of person who completed cause of de

31. Date filed (Month, Day, Year)

FEB 09

urratis

DHMH 17 Rev 7/2009

(Item 23a) (Type, Print)

OAU

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Suite

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #30 Per ANA BD (912 2/09/2011 JH State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year 24, 1:07 AMM Robert Alan Myers January 2011 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Hagerstown

| If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year)
| May 9, 1936 226 Potomac Heights Washington 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign Country) Maryland 7. Age (In yrs. last birthday) 1 X M 2 □ F Yrs 9, 217-32-6509 74 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21742 USA 226 Potomac Heights 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Armed Forces? 1 ☐ Never Married 2 Married Specify: white If Yes, Give Year or Dates: 1 ☐ Yes 2K No Specify: 3 Widowed 4 Divorced 1965 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) technician electronics 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Orville Hartman Myers Dorotha Mae Long 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 226 Potomac Heights; Hagerstown, Maryland 21742 Patsy W. Myers - wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 □ Other (Specify) 21. Signature of Funeral 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, Maryland 21201 23a. Part L. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on such line. Approximate Interval Between Onset and Death Immediate Cruse (Final MONTH disease or condition resulting in death) 105 Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy performed? Yes 2 No 1 ☐Yes 2 ☐ No 1 □ Yes 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Physician /Medical Examiner

permit. Pages
Department of Important: If its any injury or o

Physician

Examiner

Funeral

Director

death with the Maryland

Pages 1 and 2 should be filed within 72 hours after death with the Marylan ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Exambra mast be notified at

Baltimore, Maryland 21215-0036

/Medical

10a. State

MD

Director

Funeral

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Completed

Be

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Examiner and burialphysician sthe burial as attending nse for ed by the a signed to be detailed peen page 2 s certificate director, After this funeral Certification: death.

requires that the death certificate be execu

P.O. Box 68760,

Division of Vital Records,

Physician:

Hospital or Attending

24 hours after death Funeral Director: filled in by the

completely

the within 7

Physician/Medical þ Completed Be ဥ

Medical

3 Suicide

29a. Certifier

4 Homicide

(Check only

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 2 ☐ Accident

28a. Date of Injury (Month, Day, Year) 5 Pending investigation 6 ☐ Could not be

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined

28b. Time of 28c. Injury at Work? 1 ☐ Yes

2 🗌 No

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28d. Describe how injury occurred

29b. Signature and title of certifier

29c. License number

20

29d. Date signed (Month, Dav. Year)

30. Name and address of person who completed cause of ceath (Item 23a) (Type, Print)

Steven Ludden HatiebeYg Northpoint Infernal MED Ste 203 Hagerstown,MD

State Registrar 31. Date filed (Month; Day, -Year) 32 Agistrar's Signatur FEB 0 9 201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

#14 Per ANA BD G 912 2/09/2011 JH
State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2 Day Z 0 11 12:09 A M Betty L. McLaughlin Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Union Memorial Hospital Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 6. Şex **Funeral** Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign May 20, 19251 □ M 2 🖾 F Days Hours Min. Alabama **Director** 267-20-3733 85 Yrs Usual Residence of Decedent show 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director ems 23a or 28a-f sher r must be notified a 1X Yes 2 ☐ No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 700 W. 40th Street 21211 USA within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🌣 No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Medical Examiner Black, White, etc. ò ğ 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 White 1 Yes 2 No Specify: Specify: black "natural" Completed 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 中 religion minister permit. Page 1 and 2 should be filed Department of Health and Mental Hyg Important: if item 27 is marked other any injury or other traumsers traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Ruby Ward Melford Jefferson Lankford 19a. Informant's Name/Relationship (Type, Pnint) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 302 N. Morris St; Oxford, Maryland 21654 Elizabeth Simpson - daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from Sta 4 □ Donation 5 ₩ Other (Specify) in state 22. Name and Address of Facility State Anatomy Board of Runeral Sovice Licensee Ronald S Wake Director 655 W. Baltimore St; Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Sepsis Onset and Death Physician/ disease or condition resulting in death) days Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Exami Hospital or Attending Physician: The law requires that the death certificate be executed and-trans that initiated events resulting in death) Last Due to (or as a consequence of) attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Pregnant at time of death 5 Other (specify) Month Day Year ed by the a 9 Unknown 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed' 1 Yes 2 No Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 1 No Other: 1 Yes မှ 1 Impatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending 2 Accident 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🕒 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) 29b. Signature and title of certifie 29c. License number AT 243 8946-A7 2/1/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Foster Leanne Union Memorial 201 E. University Pluny Baltimon, MD 21218 Hospital

State Registrar 9"2011

32. Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

#30 Per Dyr G912 2/09/2011 JH
State of Maryland 7 Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 4:50 AM February Hona Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death itizens ( Frederic K Frederick 8. Date of Birth (Month, Day, Year) Nov. 28,193 6. Sex 7. Age (In yrs. last birthday) If Under 24 Hrs Birthplace (State or Foreign Country) **Funeral** Days 1 🗆 M 2 🗷 F Months Hours Min 76 **Director** 77-30-3574 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Completed by Funeral Director 1 Yes 2 No Frederic 10e. Street and Number 10g. Citizen of What Country? ö 23a 91 or items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☐ No Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: If Yes, Give Specify: "natural", 3 ☑ Widowed 4 ☐ Divorced Year or Dates white injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 8+6 Waitress Be 17. Father's Name (First, Middle, Last, permit. Page 1 and 2 should be file Department of Health and Mental H Important: If item 27 is marked any injury or other 18. Mother's Name (First, Middle, Maiden Surnam ပ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, S 21703 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date UNK 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) 8434 . Signature of Fineral Service 22. Name and Address 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory ir rest shock, or heart failure. List only one cause any ach line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any lading to immuse cause. Enter Underlying Cause (Disease or linjury that initiated events Examiner Due to for as a consequence of burial-transit Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical that the death certificate be Box 68760 IE EEMALE yes, outcome of pregnancy
Live Birth 2 D Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 1 Yes 2 the 9 Unknown P.O. þ signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 2 No 3 ☐ Probably 4 ☐ Unknown cate has been sig page 2 should b 1 Yes Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy the Hospital or Attending Physician: The certificate Yes 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) examiner? 2 Hospital: Other: ျှ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) After this filled in by the funeral Manner of De th 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural
Accident
Suicide
Homicide work? 1 Yes 2 No 5 Pending injury To the Hosp...
within 24 hours after dec...
To the Funeral Director: Af М Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Cify or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

| Gerifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifi 29d. Date signed (Month, Day, Year) au 13971 nun address of person who completed caus of death (Item 23a) (Type, Print) 300 West Ninth Street Frederick, MD. 21701 Kaufman Robert L.

Registrar

State

31. Date filed (Month, Day, Year)

FEB 0

9 2011

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AMEND TTEM#7perFH#30perPHYS.G912,2/9/2011.WS
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 6:15 AM FEBRUARY MOORE 4, 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner BALTIMORE MANOR CARE OF DULANEY TOWSON 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 □ M 2 XF 577-24-9780 Director JUNE 22. 1914 Usual Residence of Decedent r 28a-f show notified at 10a. State 10h County 10c. City. Town or Location 10d. Inside City Limits 1XYes 2□No Funeral Director MD BALTIMORE WINDSOR MILL 10e: Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be n 2200 WILDLIFE DRIVE 21244 USA permit. Pages 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 2 any injury or other traumatic event, the Medical Examiner muonee. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify Completed by 3XXVidowed 4 □ Divorced BLACK 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 LIBRARIAN BOARD OF EDUCATION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be WALTER FINGER ပ MINNIE TALLEY 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JACQUELINE GWIN/NIECE 445 NICOLL AVE. BALTIMORE, MD 21212 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 

Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Dother (Specify) CROWNSVILLE VET.CEM. 2-10-2011 CROWNSVILLE, MD 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC. 21. Signature of Funeral Service Licensee morto 1701-31 LAURENS ST. BALTIMORE, MD 21217 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Fnd Stuge /Medical Due to (or as a consequence of): Examiner ongestive Se pontially list and it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Chronic the burial-tra Due to (or as a consequence of): s been signed by the attending physician should be detached for use as \*\*\* \*\*\*\* Physician/Medical LOWLA IF FEMALE: 23c. If yes, outcome pf pregnancy
1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? Year Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Inknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed' 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 1 ☑ Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 02-07-11 30. Name and address person who completed cause of death (Item 23a) (Type, Print)

within 24

or Attending Physician:

24 hours after death Funeral Director:

The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

State Registrar

31. Date filed (Month, Day, Year)

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32. Registrar's Signature B. park

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**ORIGINAL** 

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MD

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Jane Ann February 5:36PM Medical 2011 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Gilchrist Hospice Baltimore Towson Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🕱 F Pennsylvania (Month, Day, Year) 04/30/1964 Director 174-54-3181 Yrs 46 Usual Residence of Decedent show 10a. State 10b. County with the Maryland notified at 10c. City, Town or Location Director 10d. Inside City Limits 28a-f PΔ Lehigh 1 X Yes 2 No Allentown ò 10e Street and Number 10f. Zip Code er than "natural", or items 23a of the Medical Examiner must be 10g. Citizen of What Country? Funeral 823 East Walnut Street 18109 U.S.A. Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, ģ 1 Never Married 2 X Married Black, White, etc. 1 Yes 2 If Yes, Give Year or Dates Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 Divorced 4 Divorced Specify White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 7 is marked other the raumatic event, the 5+ Special Education Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ of Health and Menta fitem 27 is marked rother traumatic e Joe Andrew Quigley Doloris Brunovsky Kathern 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Arthur Nixon / Husband 823 East Walnut Street, Allentown, PA 18109 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a
Department of H
Important: If ite
any injury or ott Date 20c. Location - City or Town, State  $\square$  Burial 2  $\square$  Cremation 3  $\square$  Removal from State 4 ☒ Donation 5 ☐ Other (Specify) Anatomy Gifts Registry 02/04/2011 Hanover, Maryland 21. Signature of Ineral Service Li 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause an each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Sycus Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Cause (Disease or iinjury that initiated events and resulting in death) Last Due to (or as a consequence of): attending physiciar Physician/Medical Box 68760 the as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Pregnant at time of death Day Year signed by the a g Unknow Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, Completed 1 ☐ Yes 2 Mo 3 ☐ Probably 4 ☐ Unknown peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 s performe certificate Yes 2 No 1 Tyes 2 🗌 No **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Tyes 2 No Other: ٩ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🗹 Other (Specify) 🏎 SP 🕈 this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28b. Time of 1 Natural After 28d. Describe how injury occurred 5 Pending iniury 24 hours after death. Funeral Director: A Investigation 6 Could not be completed filled in by the Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Our tifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check within 2 To the F 3 [ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

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32. Registrar's §

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			For			ck Indelible In Department of Certificate of	Health and		_	gible. 11 03456
	Physicia Medic		1. Decedent's Name (First, Middle, L.  Austin Oc	<sub>ast)</sub> den		Certificate of	Death	2. Date of De Month Janua	Day	3. Time of Death 2 0 1 1 2 : 2 0 p M
-	Examir		4a. Facility Name (if not institution, gi	ve street and number)	ical Ce		or Location of Dea		4c. County	
	Funeral Director		5. Social Security Number 6.		ge (In yrs. last bir		If Under 24 Hrs	. (Month, Da	rth	9. Birthplace (State or Foreign Country) Maryland
	aryland a-f show fied at	Director	Usual Residence of Decedent           10a. State         10b. County           MD         Baltin	nore	10c. City, Tow	on or Location				10d. Inside City Limits 1 ☐ Yes 2 🏿 No
	vith the Ma 23a or 28 ist be noti	eral Dire	10e. Street and Number  13 Boulder Cour			10f. Zip Code	1030		10g. Citizen of V	What Country?
036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ed by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent	Ever in U.S.	13. Was Decedent of If Yes, specify Cub	oan, Mexican, Puer	Specify Yes or No- to Rican, etc.)	Blac	ce - American Indian, ck, White, etc. Black
4US+in	ithin 72 houn ene. r than "natui the Medical	Completed	15. Decedent's (Specify only highest ( Elementary/Seconday (0-12)	Education		a. Decedent's Usual Occu (Give kind of work done life. DO NOT use retired Infa	during most of wo	orking		usiness Industry
Jand 2	d be filed w Vental Hygi arked other atic event, t	To Be	17. Father's Name (First, Middle, Last				18. Mother's Na	ame (First, Middle esday	, Maiden Sumame	
Man	d 2 shoul ealth and I n 27 is m er trauma		19a. Informant's Name/Relationship Wednesday Hens			b. Mailing Address (Stree:				State, Zip Code) aryland 21030
$\mathcal{O}\mathcal{C}\!(e_D)$ Baltimore, Maryland	Page 1 an ment of He ant: If iten ury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☒ Other (Spe			of Disposition (Name of ery, crematory or other pla		Date		- City or Town, State
Balti	permit. Departr Imports any inju		21. Signature of Funeral Service Lice	Wade Dir	eetor	22. Name and Addr				ard , Maryland 21201
	Physician/		23a. Part 1. Enter the disease, or co shock or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	mplications that cause one cause on each lin	ed the death. Do ne.	not enter the mode of dyi	ng, such as cardia	c or respiratory a	rrest,	Approximate Interval Between Onset and Death 49 min
	Medical Examiner	ər		b. INCO	MPCT	ENT CE	RUIY			
	be executed sician and burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	с	a consequence					
092	cate be ey physician s the buria	ज़्र		d						
. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transic.	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1  Live Birth 4  Pregnant 9  Unknown	2 Fetal deat at time of death	h 3  Ectopic pregnar 5  Other (specify) _	ncy			ate of delivery onth Day Year
ds, P.O.	quires that the signed by and be detacted		Part II. Other significant conditions	contributing to death	but not resulting	in the underlying cause g	iven in Part I.	1		ribute to the cause of death?  3  Probably 4  Unknown
Recor	The law recate has been page 2 sho	Completed by						24a. Was auto perf 1 \sum Yes	psy (	Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
Vital	hysician; this certific al director,	To Be	25. Was case referred to medical examiner?  1 Yes 2 X No			utpatient 3 DOA Ot			dence 6 Oth	er (Specify)
Division of Vital Records,	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 s	Certificate:	27. Manner of Death  1	be 280 Place of In	ay, Year)	Time of injury 28c. Inju wor 1 C	¹k? ☐ Yes 2 ☐ No		how injury occurrence of the street and Number	ed er or Rural Route Number,
Divi	spital or a nours after neral Dire		29a. Certifier 1 Certifying Ph	nysician: To the best of	f my knowledge,	death occured at the tim	e, date and place,	City or Too	vn, State)	er as stated.
	To the Ho vithin 24 l To the Ful сотреете	Medical	(Check 2 Medical Exar	miner: On the basis of	examination and/o	or investigation, in my opin rledge, death occurred at t 29c. Licens	ion, death occurred he time, date and p	at the time, date	and place, and due ne cause(s) and ma	e to the cause(s) and manner stated
	)		30. Name and address of person who	completed cause of c	death (Item 23a)	(Type, Print)	0391	12	1/1	5/11
	Stat		Ginny Marryman, M. 1 31. Date filed (Month, Day, Year)		Revilion rar's Signature	West, 656	9 N. Cha	ules St	·, #501	Towson, MD
DHN	Registra MH 17 Rev 7/20		FEB 0 9 20	11 Jenna	B. 7	facel			<del></del>	

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ February 6 201 DP Medical City, Town, or Location of Death 4a. Facility Name (if not institution, give street **Examiner** MOI In are Age (In yrs. If Unde ar If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** 1 M 2 D F Country Months Hours Director Usual Residence of Decedent show 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland notified at Director 1 Yes 2 No 28a-f Itimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö event, the Medical Examiner must be 502 by Funeral items 23a 9199 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces? 1 ★ Yes 2 □ Black, White, etc. ö 1 Never Married 2 Married 1 Yes 2 No Specify. Specify: and Mental Hygiene. is marked other than "natural", 3 Divorced Completed White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 2+ Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WD 91991 item 27 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If ite any injury or otl ☐ Burial 2 Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 18434 21. Signature of unival Service License 1933 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, of heart failure. List only one cause on each line Interval Retween Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last use as the burial-transit Due to (or as a consequence of) attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) Pregnant at time of death 9 Unknown the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed of smoking

Physician/ Medical Examiner

P.O. Box 68760 Division of Vital Records, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director,

page 2 should be detached for

Be

Certificate: To

Medical

24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of death?

26. Place of Death (Check only one)

4 Nursing Home 5 Residence 6 Other (Specify)

1 ☐ Yes 2 ☐ No

27. Manner of Death 1 Natural

examiner?

25. Was case referred to medical

5 Pending Investigation Accident Suicide Could not be 4 Homicide determined

2 No

1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year)

28b. Time of injury

and Alcohol

28c. Injury at work?
1 Yes 2 No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other:

28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number,

Drive Baltimore MD 21237

🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 

Signature and title of cert

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Elizabeth 9000 Franklin

Hospital:

State Registrar

DHMH 17 Rev 7/2009

6-40NJic 31. Date filed (Month, Day, Year) FEB 09

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2011 2010 Month 3ΰ, 11:30 A M Harriett Podboy January 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Broadmeade Retirement Community Cockeysville | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month Days | Hours | Min. | Oct 13, 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) 1 ☐ M 2 🖾 F Yrs. Virginia 230-07-6619 93 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Baltimore Cockeysville 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 21030 USA 13801 York Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married white 1 ☐ Yes 2 🖾 No Specify. Specify. 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) own home homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lucy Ann Garrett John Marshall Watts 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ret 1 Bay 25A; 350 Sardis Rd; Amherst, VA 24521 Harriett Beazley - cousin 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee ROTIA S 22. Name and Address of Facility State Anatomy Board rector 655 W. Baltimore St; Baltimore, Maryland 21201 23a. P v11. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shick, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CONGE disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Year Dav 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 1 □Yes 2 **D**No 2 □ No 25. Was case referred to medical 26. Place of Death (Check only one) Other ecify)

/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transi Vital Records, P.O. Box 68760, attending p s been signed by the should be detached

certificate has

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completely

within 24 hours after death.

To the Funeral Director: A

Division of

Physician

Examine Physician/Medical ģ Completed page 2 Be Medical Certification: To funeral filled in by

Physician

/Medical

**Examiner** 

10a. State

MD

Funeral Director

Completed by

Be

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**Funeral** 

**Director** 

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm McClan Evanulus II. and be notified at once.

30/2011

9 ☐ Unknown	9 🗆 Unknown	O LI Other (Speeny)
_	s contributing to death but not resulting in	the underlying cause

	itions contributing to death but not resulting in the underlying cause given in Part I.
ATRIAL	FIBRILLATION

1 ☐ Yes 2 ☑ N	lo	Но	spital:	2	
27. Manner of Death 1 ∠ Natural 2 ☐ Accident	5 Pending investigation		28a.	Date of Injury (Month, Day, Ye	ar)
3 ☐ Suicide	6 ☐ Could not be determined	Э	28e.	Place of Injury	At h

	1 ☐ Inpatient	2 🗆	ER/Outpatient	3 🗆 [	AOC	011101.	Nursing	Home	5 🗌 Residence	6 ☐ Other (Sp
28a.	Date of Injury (Month, Day, Ye	ar)	28b. Time of Injury	М	28c.	Injury at Work? 1 □ Yes	2 □No	28d	Describe how inj	ury occurred

be d	28e. Place of Injury - At home, farm, street, factory, building, etc. (Specify)	office	

	28f. Location (Street and Number or Rural Route Number, City or Town, State)
J	

29a. Certifier (Check only one)			of examinatio		irred at the time, date and place, and due ation, in my opinion, death occurred at th	
29b. Signature and	title of certifier	0,	111	710	29c. License number	29d. Date signed (Month, Day,

one)	and manner stated.			
. Signature and title of certifier	1. 11	210	29c. License number	29d. Date signed (Month, Day, Year

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BARBARA CAR	ROLL, M.D., 13801	YORK RD.	COCKEVSVILLEMI
31. Date filed (Morith, Day, Year)	32. Aegistrar's Signature	,	
FEB 0 9 2011	Down B. Sarles		

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Donal D. Payton Physician/ Month M Medical ebruary 1650 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death BelAir Harford Upper Chesapeake Medical Center 6. Sex 1 ፟ M 2 ☐ F If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Days Hours 9-2-1927 Yrs West Virginia **Director** 232-34-9636 83 Usual Residence of Deceden or 28a-f show Director 10b. County er than "natural", or items 23a or 28a-f sho, the Medical Examiner must be notified at 10a, State 10c. City, Town or Location 10d. Inside City Limits Md. Balto. Perry Hall 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4354 Chapel Road 21128 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. े|3||) | (50 मा।) Baltimbre, Maryland 21215-0036 þ 1 Never Married 2 Married 1 Ves 2 No If Yes, Give 1 1946-1947 1 ☐ Yes 2 🛣 No Specify: Completed 3 X Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Electrician Bethlehem Steel ! should be filed with h and Mental Hygien 7 is marked other tt Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ John Payton Vestie Cremeans and 2 should be Health and Mer tem 27 is marke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 Department of Healti Important: If item 2; any injury or other t Danny Payton 3704 Mill Road Abingdon, Md. 21009 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Holly Hills 2-7-2011 Middle River, Md. 21. Signature of Funeral Service Li Schimunek Funeral Home 22. Name and Address of Facility 9705 Belair Road Nottingham, Md. 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ CARDIOPULIONARS disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner OBSTRUCTIVE DIMMARY CYRONIC DISTASE if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) PULMONARY Cause (Disease or iinjury that initiated events というでんてもいろいつ Due to (or as a consequence of) resulting in death) Last or Attending Physician: The law requires that the death certificate be ex-Physician/Medical AMONGSING IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ASBESTOSIS Records. Completed 1 X Yes 2 No 3 Probably 4 Unknown ARUS E 24b. Were autopsy findings available prior to completion of cause of TOBACCO 24a. Was an has autopsy death? certificate 1 Yes 2 No 1 Yes 2 No of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No 1 Yes Other: မ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred **X** Natural 5 Pending injury work? 1 🗌 Yes Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 🗌 Homicide City or Town, State) Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check within 2 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) K-NA CHANSON. NO 02/04/2011 DO07 0887

State Registrar 3:>

Donce

32. Registrar's Signature

FLO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

EB 0 9 2011

KINDE CHANDERS

21014

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Petro 11 Physician Month CRaig AM Janualu :05 /Medical 7011 4a. Facility Name (If not institution, give street and number) Examiner 4c. County of Death Future Care Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, June 19, 9. Birthplace (State or Foreign Country)
New Jersey **Funeral** 7. Age (In yrs. last birthday) 19<u>51</u> Days Hours 1⊠ M 2□ F Min. 136-46-9672 June Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, Item M. dical Evanina in ust be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Baltimore Funeral Director 1 ☐ Yes 2 ☑ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1300 S. Ellwood Avenue 21224 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 þ 1 ∐Yes 2X No Specify. white 3 ☐ Widowed 4 ☐ Divorced Specify: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) waiter restaurant 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) 1111 k ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ralph McGraw - friend 207 E. Preston St Apt 1A; Baltimore, MD 21202 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 ♥ Other (Specify) in State Signature of Euneral Service Licensee Ronal On and Service Ronal On and 22. Name and Address of Facility State Anatomy Board Director 655 W. Baltimore St; Baltimore, Maryland 21201 23a. Part Lenter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Ca End-Stages AIDS Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate occurs. It is a comparable occurs to the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the condition of the conditions, if any leading the conditions, if any leading the conditions, if any leading the conditions, if any leading the conditions, if any leading to immediate occurs of the conditions of the condition of the conditions of the con Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician a for use as the burial Due to (or as a consequence of): Physician/Medical IF FFMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 🔲 Ectopic pregnancy Day Year 4 Pregnant Pregnant at time of death 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown has been 24b. Were autopsy findings available prior to completion of cause of death? certificate has be rector, page 2 s 24a. Was an autopsy performed 1 □ Ýes 2 🗀 No within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 
Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

State Registrar

Division of Vital Records, P.O. Box 68760,

31. Date filed (Month, Day, Year) FEB 0 9 2011 DHMH 17 Rev 1/2001

Medical

29a. Certifier (Check only one)

29b. Signature and title of certifier

NSKAJAPANNEM.D

and manner stated

32. Registrar's Signature

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
N.S. Kayapaksem. D. 2835 Smith N-5-203, Balt note, MD 7/700

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D0057465

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) Wayne Gamalion 2. Date of Death 3. Time of Death Pringle Physician/ February Day 5, 2011 1924P Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Montgomery Examiner 4b. City, Town, or Location of Death Washington Adventist Hospital Takoma Park 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, June 24 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral Days 1 🔀 M 2 🗆 F Hours 212-54-0916 Director 948 Virginia Usual Residence of Decedent or 28a-f show e notified at Prince Georges 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director Forestville 1 ¥ Yes 2 □ No 10e. Street and Numbe 10f. Zip Code 0 10g. Citizen of What Country? ms 23a or must be Funeral 2120 Brocks Drive Apt. 307 20747 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc or. þ 1 Never Married 2 Married 1 Yes 3altimore, Maryland 21215-0036 1 ☐ Yes X☐ No Specify: Specify Black 3 Widowed 4 Divorced "natural", Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me College (1-4 or 5+) Welder Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ James H. Pringle Sr. Mary Poindexter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code,  $9313\ Lavall\ Dr.\ Springdale,\ MD\ 207$ James H. Pringle Jr. 20774 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Nathalie, VA Millstone Baptist 02/19/2011 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 20019 22. Name and Address of Facilit 5635 Eads St. NE Washington, D. Dunn&Sons 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) erebrovenculou Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of) been signed by the attending physician and should be detached for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has t completed filled in by the funeral director, page 2 s autopsy performed 1 ☐ Yes 2 ☐ No Yes 2:HN Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 No Other: 1 Yes မြ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural iniury 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D063703 0210712011 jasach las MD 7600 CACROLL AVENUE 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SABYASACHI UNR TAKOMA PARK, MD

DHMH 17 Rev 7/2009

Registrar

31. Date filed (Month, Day, Year)

legistrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First Middle, Last) 2. Date of Death Physician/ Month Minnie Wingate Powell Day 20 2ci Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death N/A Good Samaritan Hospital Baltimore 5. Social Security Number Funeral 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 X 219-28-3692 Months Days Hours Min. 10723/ Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the war, were Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f should provide the marked other than "natural", or items 23a or 28a-f should be notified at the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director MD N/A Baltimore 1X Yes 2 No 10f. Zip Code 21206 10e. Street and Number 7410 Beech Ave 10g. Citizen of What Country? USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. Completed by 1 Never Married 2 X Married 1 ☐ Yes 2X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: 3 Widowed 4 Divorced Year or Dates Amer. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Johns Hopkins Medical Records Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Ruffin Fannie Ruffin Powerl 19a. Informant's Name/Relationship (Type, Print)
Alfred Powell/Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7410 Beech Ave, Balt., MD 21206 20a, Method of Disposition 20b. Place of Disposition (Name of 2/12/11 20c. Location - City or Town, State Parkwood

cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Balt..MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hari P. Close F.Svs, PA 5126 Belair Rd, Balt., MD 21206-5105 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death EUMONIA Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Pregnant at time of death Month the 9 Unknown been signed by should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of page 2 s autopsy performed? Yes 2 death? certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) examiner? 2 No Certificate: To 1 🗌 Yes Other: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this ( 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) . Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 1 Natural 5 Pending Accident Investigation 2 No 24 hours after deat Funeral Director: filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, ueath occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) -G.B = 2, 05, 2011 QC5 000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

301007099

5601

Loch Raven Boulevard Baltimore MD21239

BASSI

32. Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle Last) 2. Date of Death 3. Time of Death Physician/ Mostb2 0941 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death TATEHOSPICE Linthicum Anne Arundel 8. Date of Birth
(Month, Day, Year)
21, 1925 If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral 9. Birthplace (State or Foreign 1 M 2 F 85 216-20-0876 West Virginia Director Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director ortant, If item 27 is marked other than "natural", or items 23a or 28a-f s injury or other traumatic event, the Medical Examiner must be notified Maryland Anne Arundel 1 Yes 2 No Arnold 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 352 Kimwood Road 21012 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? 1 ☐ Yes 2 ☐ No Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White If Yes, Give 3 X Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 10 College (1-4 or 5+) Westinghouse Assembly Work Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ J.C. Martin Verginia Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joyce Riggin (Daughter) 250 Pickett Court, Arnold , Maryland 21012 20a. Method of Disposition 20b. Place of Disposition (Name of Department of H Important: If ite any injury or oth 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) emetery, crematory or other place, Cedar Hill Cemetery Feb. 14,2011 Brooklyn Park, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service License \_McCully-Polyniak Funeral Home P.A. 3204 Mountain Road, Pasadena, Maryland 21122 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death PARKINSON'S mediate Cause (Final Physician/ isease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of) physician and the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical P.O. Box 68760 attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate har funeral director, page performed Yes 2 1 Tes 25. Was case referred to medical 26. Place of Death (Check only one) Be 2. No Hospital: Other: 1 Tyes ည 1 Inpatient 2 ER/Outpatient 3 DOA HUSPICE 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at HUSI 28d. Describe how injury occurred 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending injury within 24 hours after death.

To the Funeral Director. Aft completed filled in by the fun 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of 082011 who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 7/2009

State

Division of Vital

ENAM

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item State of Maryland / Department of Health and Mental Hygiene / Certificate of Death

State of Maryland / Department of Health and Mental Hygiene / Certificate of Death

Reg. No. For State Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) Malyip Robinson 3. Time of Death Physician/ ) Ze 80 N Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death SEASONS HOSPICE @ NORTHWEST HOSPITAL RANDALLSTOWN BALTIMORE 6. Sex If Under 1 Year If Under 24 Hrs. **Funeral** Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Days 1 XM 2 □ F Min Hours 01/30/1917 Director 061-05-1836 94 MD Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director MD BALTIMORE 1 Yes 2X No BALTIMORE 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 6802 OLD PIMLICO ROAD 21209 USA items death v 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. "natural", or 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 🕅 No Specify: If Yes. Give Completed 3 Widowed 4 Divorced WHITE Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Page 1 and 2 should be filed within ment of Health and Mental Hygiene. the 12 SALES INSURANCE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ PAUL ROBINSON FRANCES KAFKA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 is I permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr BEVERLY ROBINSON/WIFE 7920 SCOTTS LEVEL ROAD, BALTIMORE, MD 21208 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other plants of the control 1 K Buriat 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 02/02/2011 BALTIMORE, MD Signature of Funeral Service License 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on the line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Minig Medical Due o (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or linjury and that initiated events resulting in death) Last the burial-tran Due to (or as a consequence of): attending physician Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day been signed by the s should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 ⋈ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s has autopsy perfor death? Director: After this certificate ☐ Yes Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? hes Certificate: To Other: 1 Tyes 2 **4**No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be completed filled in by the Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) To the Hospital within 24 hours To the Funeral Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Gertifying Nurse Practioner: To the best of my Provis

Registrar

State

29b. Signature

31. Date filed (Month, Day, Year)

FEB 0

30. Name and address of person who completed cause of death (Item 23a)

9

3 9

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 3. Time of Death Physician/ Month TOWARD ITENOUR FEBRUARY 2011 4:05 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death BAYVIEW MEDICALIENTOR JOHNS HOPKINS BALTIMORE 5. Social Security Number If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 **X**M 2 □ F Days 216-34-9118 73 Director MD Usual Residence of Deceden show 10a. State 10b. County be filed within 72 hours after death with the Maryland Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits or 28a-f PA York Railroad 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral "natural", or items 23a 40 S. Main Street 17355 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Completed by Yes Yes, Give 2 **N**No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: 3 Widowed 4 Divorced Specify: White Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) l Hygiene. I **other than** " Elementary/Seconday (0-12) College (1-4 or 5+) Disabled Disabled Be Mental Hy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Howard W. Ritenour, Sr. Mildred Harris and I 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Grace Ellis - Sister Main Street, Railroad, PA 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) John's Cem. 2-11-2011 Ellicott City, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bradley-Ashton Funeral Home 2134 Willow Spring Road, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph\_sician/ CARDIAC ARREST disease or condition hours Medical resulting in death) Examiner ASTROINTESTINAL BLEED Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day Pregnant at time of death Year Yes 2 No signed by the a d be detached f g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by has been signed 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate ha performed? Yes 2 ☑ No 2 🗌 No 1 Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner' 1 ☐ Yes 2 ☑ No Hospital Other: ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work' 1 Tes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Funeral 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) Signature and title of confiler 29c. License numbe. RFS-000 FEBRUARY 5 2011 MP s of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 4940 Eastern Ave Baltimore MD 21224

Graham

31. Date filed (Month, Day, Year)

FEB

MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 12-30 A M 02 J. 04 VINCENT 2011 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore <u>Genesis Healthcare</u> Baltimore
nder 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Year) Days 1 X M 2 □ F Director 215-52-2833 10/08/1950 Maryland 60 Usual Residence of Decedent be filed within /2 mou...
shall Hygiene,
sed other than "natural", or items 23a or 28a-f show
ide event, the Midcal Eval, fructional be multipled at 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐Yes 2 X No Director Harford Joppa 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 103 Stone Harbor Court 21085 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 ∐Yes 2 ⊠ No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1∐Yes 2X No Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Construction Truck Driver permit. Pages 1 and 2 should be filed in Department of Health and Mental Hygin Important: If item 27 is marked other any Injury or other traumatic event. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ္ပ John James Riley Florence J. Myers 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Angela M. Highkin / Sister 103 Stone Harbor Court, Joppa, MD 21085 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) Anatomy Gifts Registry | 02/07/2011 | Hanover, Maryland 21. Signature of Funeral Service Livensee 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician metastetu disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Progressie if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner attending physician and for use as the burial-transit executed Moslahe resulting in death) Last Due to (or as a consequence of): Box 68760. requires that the death certificate be Physician/Medical IF FEMALE yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Day Year 5 ☐ Other (specify) P.O. 1 ☐ Yes 2 ☐ No been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an r this certificate has ral director, page 2 s autopsy performed? 1 □Yes 2 No 2 UNO 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After thi funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined

To the Hospital or Attending Physician: Division within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

> State Registrar

Medical

29b. Signature and title of certifier

4 Homicide

29a. Certifier

MD

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D 31464

29d. Date signed (Month, Day, Year)

5

11-00600 Lisa Robinson Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2011 23467
State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar		Ce	rtificate of	Death			Reg. No.	
hysici Exam		1. Decedent's Name (First, Mic Lisa Der	ise Robi					2. Date of D Month January	Peath Day Yea 21, 2011	2355 nrs
		4a. Facility Name (if not institu Fort Washington	4	b. City, Town, or L Fort Washi		ath	4c. County of Prince C			
ineral rector		5. Social Security Number Unknown	6. Sex	7. Age (In yrs. 43	last birthday) Yrs.	If Under 1 Year Months Days			Birth(MM/DD/YYYY 21/1967	y) 9. Birthplace (State or Foreign NC Country)
how any		Usual Residence of Decedent 10a. State 10b. Count MD Prir	y ice Georg	es 10c. City	Town or Location					10d. Inside City Limits
items 23a or 28a-f show ust be notified at once.	Director	10e. Street and Number 518 Wilson	Bridge D	rive		10f. Zip Code 20745	5		10g. Citizen of Wh USA	nat Country?
SH	Ĭ,	11. Marital Status 1 Never Married 2 3 Widowed 4		2 No	If Ye	Decedent of Hisp es, specify Cuban, Yes 2X No	- American Indian, Black, e, etc. Black			
inelle of treath and brethat tryglette.  tant: If item 27 is marked other than "natural", or other traumatic event, the Medical Examiner	Completed by	15. Decedent's Education (Sp Elementary/Secondary (0-12	l or Dates: pecify only highest gra	de completed)	16a. Decedent during mo	's Usual Occupationst of working life. I	n (Give kind		16b. Kind of Bu	
ked other th	Be Com	12th 17. Father's Name (First, Midd Willitant A			неатт	h Care		me (First, Middlers Whit	e, Maiden Surname	
n 27 is mar numatic eve	To E	19a Informant's Name/Relation Jamah Robir			2300	Good Ho	pe RC	ad Apt	c.411 Wa	n, State, Zip C2000 220 shington, DC
tant: If item 27 or other traum:		20a. Method of Disposition  1 XBurial 2 Cremati  4 Dopation 5 Other	Specify:	om Ctota	crematory or oth critage	Cem.	01	Date / 27/20		City or Town, State .dorf, MD
Impor injury		21. Signature of Funeral Service		guesd the death	Du	nn&Sons	563			Washington
23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shown that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shown that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shown that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shown that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shown that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shown that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shown that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shown that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shown that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shown that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shown that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shown that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shown that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shown that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shown that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shown that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shown that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shown that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shown that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sho							arrest, snock, or nea	Approximate Interva Between Onset and Death		
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g physician and the burial - transit	edical	X UNPENDED	d AMENDED	23a,27	per me	g914 4-15	5−11 vt			
e attendin for use as	ΣI	IF FEMALE: 23b. Was decedent pregnant in past 12 months?  1 ☐ Yes 2 ☐ No 9 ✔ U	the 1 Live b	ant at time of de	2 Feta	al death 3 er (Specify)	Ectopic preg	nancy	23d. Date of Month	delivery Day Year
has been signed by the 2 should be detached	23e. Did tobacco use contributing to death but not resulting in the underlying cause given in Part I.								bute to the cause of death?  Probably 4 Unknown	
	Completed	\\	<del>_</del> .					pei	opsy p	Vere autopsy findings available vior to completion of cause of leath?  Yes 2 No
≃ I	Be	25. Was case referred to medic examiner?	11	anationt 2	ER/Outpatient		f Death (Chec	sk only one)	Residence 6	701
or: After this	ition: To		28a. Date (Month		28b. Time of Inj	ury 28c. Injury	- Truit		e how injury occurre	Other:
Direct d in by	Certification:	3 Suicide 6 Code det	estigation 28e. Plac ald not be ermined (Specify)	e of Injury - At he	ome, farm, street	, factory, office buil	lding, etc.	28f. Location or Town		er or Rural Route Number, City
To the Funeral completely filler	edical	( who are a series )	Physician: To the bes aminer: On the basis of and manner s	of examination a		on, in my opinion, d	leath occurred		te and place, and d	ue to the cause(s)
		Meyare (	me You	an of don't /lta-	23a)	29c. License r			January 23	ed (Month, Day, Year) , 2011
		30. Name and address of perso Margarita Korell MD.	Assistant Med	dical Examin	er 900 W.	Baltimore Stre	eet, Baltim	ore, MD 212	223	
St Regist	-	31. Date filed (Month, Day, Year	) 32. Re	gistrar's Signatu	ire					
I-Tall -						. 4 11				

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		•	For State Registrar	State of Marylar		artment of F tificate of L			ene g. No.	13468
	Physicia		Decedent's Name (First, Middle, Las Lincoln	Ross Jr.				2. Date of Death Month	26,2011 Year	3. Time of Death
y	Medic Examin		4a. Facility Name (if not institution, give	street and number)		4b. City, Town, o	r Location of Death	January	4c. County of Dear	UJJZA
	•		Holy Cross Hospi  5. Social Security Number   6. So			Silver If Under 1 Year		La a la cala	Montgomer	
	Funeral Director			7. Age (In yrs. 85	Yrs.	Months Days	Hours Min.	8. Date of Birth 6 Septem	1925 9. Bir ber Trir	thplace (State or Foreign untry)
	/land f show dat	tor	10a. State 10b. County	10c. Ci	ty, Town or Loc	cation				10d. Inside City Limits
	e Mary r 28a-i notifie	Direc	Maryland Montgome	ry Sil	ver Sp					txtxYes 2 □ No
	is 23a o	Funeral Director	11514 Yates Stree	t		10f. Zip Code	20902		g. Citizen of What Conited Stat	-
21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at	þ	11. Marital Status  1 Never Married 2XXXMarried 3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 X Yes 2 ☐ No If Yes, Give Year or Dates.		Vas Decedent of H Yes, specify Cuba ☐ Yes 2 🙀 No	lispanic Origin? (Spe an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	e, etc.
15-0	72 hou "natu ledical	Completed	15. Decedent's E (Specify only highest gra	ducation ade completed)	(Give k	ent's Usual Occup	during most of work	ing 1	6b. Kind of Business	Industry
212	within giene. er thar		Twelfth F	College (1-4 or 5+) our	Denti	NOT use retired) . <b>s t</b>		н	oward Uni	versity
Maryland	d be filed dental Hyg irked oth	To Be	17. Father's Name (First, Middle, Last) Lincoln Ross, Sr.				18. Mother's Name Dorothy	e (First, Middle, Ma Edwards	iden Surname)	
	d 2 shouk alth and N 27 is ma er trauma		19a. Informant's Name/Relationship (7) Doris Ross/Wife	rpe, Print)					ity or Town, State, Zij	
Baltimore,	permit. Page 1 an Department of He Important: If iten any injury or oth once.		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Removal from State	cemetery, crem	sition (Name of eatory or other place ce Cremat	e) Febru	arv 1.	Oc.Location - City or eltsville	
Balti	permit. Departr Importa any injt		21. Sig ature Viner Seric Livens	Donald R Gra		Name and Addres	ss of FacilityRobe Hope Rd S	ert G Mas SE Washin	on Funera	1 Home Inc
	Ph_sician/		23a. Part 1/ Enter the disease, or comp shock, of heart failure. List only of Immediate Cause (Final	olications that caused the dealer cause on each line.  Acute Myocar	th. Do not ente	r the mode of dyin	g, such as cardiac o			Approximate Interval Between Onset and Death
	Medical Examiner	ì	disease or condition resulting in death)							
	ed nsit	Examiner	Sequentially list conditions, if any, leading to ministrate cause. Enter Underlying Cause (Disease or linjury)							
0	ificate be executed ng physician and as the burial-transit	edical Exa	that initiated events resulting in death) Last	Due to (or as a conseq	Due to (or as a consequence of):					
	ificate ng phy as the		F FEMALE:	u						
. Box 68	To the Hospital or Attending Physician: The law requires that the death certifi within 24 hours after death.  within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending completed filled in by the funeral director, page 2 should be detached for use a		23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	23c. If yes, outcome of pregna 1  Live Birth 2  Fet 4  Pregnant at time of 9  Unknown	al death 3 🗌	Ectopic pregnand Other (specify)	су		23d. Date of de Month	livery Day Year
ds, P.O.	quires that the series and signed by and be detailed	ed by Pi	Part II. Other significant conditions co	entributing to death but not res	sulting in the ur	nderlying cause giv	ven in Part I.		cco use contribute to	the cause of death?
Division of Vital Records,	2 8 2	Comple						24a. Was an autopsy performe	prior to	topsy findings available completion of cause of
ital	sician; certific rector,	Be	25. Was case referred to medical examiner? 1 □ Yes 2 🏝 No	Hospital:		Loui	ace of Death (Checker:			
n of V	ding Phys th. After this funeral di	cate: To	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation	1 ☐ Inpatient 2 ☐  28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury work	4 □ Nursing Ho	me 5 Residen	ce 6 Other (Specinjury occurred	ify)
Divisio	To the Hospital or Attending Physician: The la within 24 hours after death.  To the Funeral Director: After this certificate he completed filled in by the funeral director, page	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined		ome, farm, stre			28f. Location (Stre City or Town,	eet and Number or Rural Route Number, State)	
14)	ne Hospita n 24 hours ne Funera oleted fille	Medical	(Check 2 Medical Examination (Check 2 Medical Examination)	ician: To the best of my know her: If the basts of examinatio	n and/or investi	gation, in my opinic	on, death occurred at	the time, date and	place, and due to the	cause(s) and manner stated.
	vithi To th		29b. Signature and title of certifier			29c. License	e number	290	d. Date signed (Month anuary 26	n, Day, Year)
<b>}</b>			30. Name and address of person who c Peter J. Sabia MD				Silver S	Spring MD	20910	
	Stat Registra	٠ ا	1. Date filed (Month, Day, Year) FFR 0 9 2011	32. Registrar's Signa	ture					

DHMH 17 Rev 7/2009

03469

		•	For State Registrar	State of M	larylan		artment of F tificate of L		and Me		gierie Reg. No.		
	Physicia	n/	1. Decedent's Name (First, Mid	ddle, Last)					2	2. Date of Dea Month	th	y Year	3. Time of Death
	Medic	al	BORIS			F	RODNER			'EBRUAR		2011	08:40P M
	Examin	er	4a. Facility Name (if not institut	,			of Death			County of Death			
	Funeral		MANOR CARE PO 5. Social Security Number	6. Sex 7. Ag	7. Age (In yrs. last birthday) If Under 1 Year If Under 24 H					3. Date of Birth	1	1ONTGOME g. Birth	
	Director		212-32-9544 Usual Residence of Decedent	1 🛛 M 2 🗆 F	76 Yrs. Months Days Hours Min. 107057 1934							Cou	ntry) MD
	and show l at	or	10a. State 10b. Coul		10c. Cit	y, Town or Loc	cation						10d. Inside City Limits
	Maryla 28a-f	Director	MD MON	TGOMERY	CA	ABIN JO	OHN						1 ☐ Yes 2 🗓 No
	h the		10e. Street and Number				10f. Zip Code				10g. Citi	zen of What Cou	intry?
	72 hours after death with the Maryland n "natural", or items 23a or 28a-f sho Aedical Examiner must be notified at	Funeral	7916 LONG R		C:- 111	140.1	20818		-l-0 (0it				USA
(0	or ite	by Fu	11. Marital Status 1 ☐ Never Married 2 🖾 N	12. Was Decedent Armed Forces?  Married 1 \( \sum \) Yes 2			Vas Decedent of Hi Yes, specify Cuba			y yes or No- can, etc.)		<ol> <li>Race - Ameri Black, White</li> </ol>	
80	ırs aftı ıral", I Exar	ed k	3 🗌 Widowed 4 🗌 Divord	If Voc. Give		1	☐ Yes 2 🗓 No	Specify:				Specify: WHI	TE
2-0	"2 hou "natu	plet	15. Dece (Specify only hi	edent's Education ighest grade completed)		(Give F	lent's Usual Occup	ation during most	t of working		16b. Ki	nd of Business I	ndustry
21215-0036	within 7 giene. ier than t, the M	Completed	Elementary/Seconday (0-12	2) College (1-4 or :	5+)	I	O NOT use retired) PRESIDEN	T OF	FINAN	ICE		RENTA	T C
102	filed w al Hygi d other	Be	17. Father's Name (First, Middl	<u>`</u>		I VIOL	IKEGIDEN			First, Middle, I	Maiden S		.110
/lar	ould be fill nd Mental marked (	욘	ABRAHAM		]	RODNER		HEL	LEN			MARK	S
Maryland	should and Me is mar raumati		19a. Informant's Name/Relation				g Address (Street a				•		
e, N	and 2 s Health em 27 ther tr		CAROLYN RODN 20a. Method of Disposition	IER / WIFE	20h E		LONG RI	DGE C	COURT,			IN, MD 2	
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.			ion 3  Removal from State er (Specify)	AR	LINGTO:	Nto CEMETER IUNO CONG		2/7/2			ALTIMORE	
Balt	permit Depart Impor any in	l 7	21. Signature of Funeral Service	pe Licenses		22	Name and Addres	ss of Facility TERST	<sup>ty</sup> SOL COWN R	LEVINS	ON 8	BROS.,	INC. MD 21208
				e, or complications that cause ist only one cause on each lin	d the deat e.								Approximate Interval Between Onset and Death
	hysician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a. METAST Due to (or as		LUNG (	CANCER					-	2 YEARS
176 garage	Examiner	<u>.</u>	Sequentially list conditions,	b. ———									
	ed nsit	Examiner	if any, leading to immediate cause. E. ter ornaerlying Cause (Disease or iinjury	Due to (or as	a consequ	uence of):							
	execut an and ial-tra	I Exa	that initiated events resulting in death) Last C. Due to (or as a consequence of):										
3760	ificate be executed g physician and as the burial-transit	Physician/Medical		d						_			
687	ath certifica attending p	√Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregna	incy						23d. Date of deli	von:
Вох	Jeath of e atter d for u	sicial	in the past 12 months?  1  Yes 2  No	1  Live Birth 4  Pregnant a 9  Unknown			Ectopic pregnanc Other (specify)	У			1	Month Month	Day Year
P.O.	at the c d by th etache	Phy	g Unknown Part II. Other significant cond		out not rec	sulting in the u	nderlying cause giv	en in Part I	1	Too- Dida-			the cause of death?
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ecor	law require has been si je 2 should b	Completed								24a. Was a	SV	prior to c	opsy findings available ompletion of cause of
œ E	Physician: The lav r this certificate has ral director, page 2	CO e	25. Was case referred to medic	cal			26 DI	age of Doot	th (Check o		med? 2 X No	1 🗌 Yes	2  No
Vita	ysicia is cert direct	To Be	examiner? 1 ☐ Yes _2 🔀 No	Hospital:	ient 2 🗆	ER/Outpatien	_ Othe		-	-	ence 6	Other (Specia	5/)
Division of Vital Records,	iding Ph th. After th funeral		27. Manner of Death  1   Natural  5 □ Per 2 □ Accident  Inve	28a. Date of inju	irv	28b. Time of injury	28c. Injury work	/ at	286	d. Describe ho			
ivisio	l or Atteno after death Director: / I in by the i	Certificate:	3 🔲 Suicide 6 🗆 Cou	uld not be ermined 28e. Place of Inju- building, et						f. Location (St City or Town		Number or Rura	al Route Number,
Ω	oital urs ral	Medical	29a. Certifier 1 Certify (Check 2 Medica	ring Physician: To the best of al Examiner: On the basis of e	my know	ledge, death o	ccured at the time,	, date and p	place, and o	due to the cau e time, date ar	ise(s) and	d manner as stat	red. ause(s) and manner stated.
	To the Hosp within 24 ho To the Fune completed f	ž		ving Nurse Practioner: To the				e time, date		and due to the	cause(s)		stated.
			Proof.	MM	)		D31	319				4/2011	
			30. Name and address of person				rint)						
)			LORETO S. ALE 31. Date filed (Month, Day, Year	BIOL, M.D., 82	18 W	ISCONS	IN AVENUE	<b>30</b>	05, BE	ETHESDA	A, MI	20814	
	Stat Registra		FEB 0	9 2011 (See 1)	ar s Signai	1. ba	ales						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Anna Bernette Larick Rison 01 - 20 - $\tilde{2}01$ 0300 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 4328 Vine Street Capitol Heights Prince George's If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day. O3-26-Social Security Number 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 M 2 TYF 86 502-14-0956 Yrs Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director MD Prince George' Capitol Heights 1 X Yes 2 ☐ No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? rral", or items 23a or Examiner must be r Funeral 4328 Vine Street 20743 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Black, White, etc. ģ 1 Never Married 2 Married 1 ☐ Yes 2 💢 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 nan "natural", 1 ☐ Yes 2 ☐ No Specify: Specify: Completed 3 X Widowed 4 Divorced White Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 72 tal Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the Own Home Homemaker 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental P ပ Oscar Larvick Addie Carrier 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health a Important: If item 27 is any injury or other trau once. Patty Quagliarello/daughte $\dagger$ 4625 Henderson Rd.,Temple Hills, MD 20748 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 2-11-2011 Arlington Natl. Arlington, VΑ 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 20746 L. Reid Cedar Hill FH,4111 PA Ave.,Suitland, mo1616 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition resulting in death) ATheroscleratio GronAry Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months? Month Year Pregnant at time of death Day 2 🔀 No g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Mellitis 1 ☐ Yes 2 🙀 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available 24a. Was an Hypertension prior to completion of cause of death? autopsy performed Hyperlipidemi 1 ☐ Yes 2 🐼 No Yes 2 No **Division of Vital** 25. Was cas referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 X No Other: ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🗷 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work?
1 ☐ Yes Certificate: 28d. Describe how injury occurred (Month, Day, Year) injury 5 Pending 2 🗌 No 2 Accident
3 Suicide Investigation Director: / To the Hospital or Atte within 24 hours after de To the Funeral Directo completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D0030484 20814 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Umosella, MD 7625 Wisconsin Ave., Ste.101 Bethesda, MD

DHMH 17 Rev 7/2009

Registrar

31. Date filed (Month, Day, Year,

FEB 0 9 2011

32. Registrar's Si

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Feloruary Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of De **Examiner** 4c. County of Death l timore If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day) 9. Birthplace (State or Foreign . Age **Funeral** 1 🗆 M 2 📝 F Country) 07 Director er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director 1 Yes 2 No Timore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country Funeral be filed within 72 hours after death in ental Hygiene. "ked other than "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 11. Marital Status 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired, Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygier Important: If item 27 is marked other t any injury or other traumatic event, the once. Be 17. Father's Name (First, Middle, Last) မ wrai 19a. Informant's Name/Relationship (Type, Pri 🌓 (SON) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, St. e, Zip Code) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🗹 Burial 2 🗌 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Name and Address of Facility val North Avg 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each fine. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying 209/11CR signed by the attending physician and d be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year 5 Other (specify) filled in by the funeral director, page 2 should be detached 1 L Yes 2 L 9 Dunknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ş 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an certificate has performed? Yes 2 No 1 Yes 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Hospital: Other: ည 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Name Praction at Total Court and Section 2011 and the firm date and place and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of sertifie 29c. License number 0063086 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) te 31. Date filed (Month, Day, Year) State 9 Registrar

DHMH 17 Rev 7/2009

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Roy Sinclair Staup, Jr.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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State of Maryland	/ Department of H	ealth and Me	ental Hygiene

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		- For State egistrar		Certif	icate of	Death				Reg. No	).		
Physician		. Decedent's Name (First, Midd	e,Last)						2. Date of D				3. Time of Death
Medical Examine	er	Roy Sinc	lair S	taup Jr.					Month Februar	Day 4, 20	Yea⊩ 11		1131 hrs
	4	a. Facility Name (if not institutio	n, give street and no	umber)	4	b. City, Town, o	or Location	of Death		4	c. County o	f Death	
		1001 East Kinder Parl	∢ Road			Severna P	ark			1	Anne Arı	ındel	
Funeral	5	. Social Security Number	6. Sex	7. Age (In yrs, last I	birthday)	If Under 1 Ye	ear If Und		8. Date of	Birth(MN	I/DD/YYYY)		hplace (State or
Director	2	15-66-2824	1X M 2 F	55	Yrs.	Months Da	ys Hour	s Min.	10/	05/1	955	Foreig Cou	n untry) MD
	Ū	Isual Residence of Decedent							10/	03/1	933		·· MD
any	1	0a. State 10b. County		10c. City, Tov	wn or Location	on							10d. Inside City Limits
	_   1	Maryland Anne	Arundel				Pasad	lona					1 Yes 2 X No
rylar rylar	3   1	0e, Street and Number				10f. Zip Code	Lasac	tena		10a Cit	tizen of Wha	at Coun	trv?
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"nat Exa	<u> </u>	Elementary/Secondary (0-12)	College (1			st of working life				100.	Killa of Das	111633/11	rausii y
5-0036 ed within 72 hour lygiene. other than "natu the Medical Exan	2	12	1	1-4-0/-01/	Dr	oductio		n + 120 l			T-7 4		
Series Siene	1	7. Father's Name (First, Middle,			FI	Oductio			First, Middle	Maidor		rruč	house
215. be filed and Hy conf. the old		Roy Sincla		p Sr.				omi	E .		dowsk	:	
212 hould be id Ment iis mark	19	9a. Informant's Name/Relations			19b. Mailing	Address (Stre							Zin Code)
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene.  unt: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Firmeral Director		Naomi E. Staup	(mot			ate Dri						, 0.2.0,	Lip Godo)
and 2	_	0a. Method of Disposition	(11100			ion (Name of ce	•		Date			City or 7	Town, State
Ses 1 Fof F	1	Burial 2 X Cremation	3 Removal fr	om otate	atory or other		-	Feb	. 07			•	
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Baltimore, MD 21215-003 permit. Pages I and 2 should be filed withi Department of Heath and Mental Hygiene. Important: If iten 27 is marked other ti injury or other traumatic event, the Med	2	1. Signature of Funeral Service	Ligensee		22. Na	me and Addres	ss of Facilit	Sta	alling	s Fu	neral	Но	me, P.A. 122
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Physician	20	3a. Part I. Enter the disease, or failure. List only one cause	on each line.	aused the death. Do	not enter the	e mode of dying	, such as o	cardiac or i	respiratory a	rrest, sn	ock, or hear	τ	Approximate Interval Between Onset and
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6	S	equentially list conditions, any, leading to immediate	Due to (or as a	consequence of):								_	
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otephen ochmor		1- For State Control of Department of Death Registrar Certificate of Death		eg. No.	193473
Physicia Medical Examin		1. Decedent's Name (First, Middle,Last)	2. Date of Dea Month February		3. Time of Death 1659 hrs
Medical Examin	C	Stephen Bruce Semmont  4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death		1, 2011 4c. County of Deat	
		Harbor Hospital Center Baltimore		N/	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs Months Days Hours Min.	_	th(MM/DD/YYYY) 9. Bi Forei	rthplace (State or
Director		215-66-1455 1XM 2F 55 Yrs.	12/08		ountry) MD
ki w	ŀ	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	ڃ	Maryland N/A Brooklyn			1 X Yes 2 No
Maryland 28a-f show d at once.	Director	10e. Street and Number 10f. Zip Code	1	0g. Citizen of What Cou	ntry?
th the 23a or		3554 Horton Avenue 21225		USA	
more, MD 21215-0036  Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.  The matter of Health and Mental Hygiene "antural", or items 23a or 28a-f sho or other traumatie event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status  12. Was Decedent Ever in U.S.  1 X Never Married  12. Married Forces?  13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto		- 14. Race - Amer White, etc.	ican Indian, Black,
fter de	핔	1 ☑ Yes 2 No 3 ☑ Widowed 4 ☑ Divorced If Yes, Give Year 1 ☑ Yes 2 ☒ No specify:		Specify: Wh	ite
nours a		15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of w during most of working life. DO NOT use retired.		16b. Kind of Business/	
36 in 72 l	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	iou)		
d with	Ĕ	12 Carpenter  17. Father's Name (First, Middle, Last) 18. Mother's Name	(First, Middle, N		ruction
21215-0036 Juld be filed within 7 I Mental Hygiene marked other than te event, the Medical	8	Albert H. Semmont Doris	Lucl	k	
D 21 thould md Me is ma	₽	19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Number or R			
MD 2 sho ealth and em 27 is	ŀ	Jane Sheesley (sister) 7661 Beth Noelle Cour.  20a. Method of Disposition 20b. Place of Disposition (Name of cemetery.	rt, Pasa Date	adena, MD 2	
IOFE iges l it of H t: If if		1 Burial 2 X Cremation 3 Removal from State crematory or other place)	b. 04		·
Baltimore, permit. Pages I ar Department of Hec Important: If tien injury or other tr	ł	4 Donation 5 Other Specify: Metro Crematory Inc 21. Signature of Funeral Service 4 ons 22. Name and Address of Facility	2011 Stalli	Baltimore,	Home, P.A.
Det De linitie		3111 Mountain Re	oad, Pas	sadena, MD	
Physician Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or failure. List only one cause on each line.		est, shock, or heart	Approximate Interval Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death)  Atherosclerotic Cardiovascular Disease or condition resulting in death)	sease		Death
		Sequentially list conditions, b.			
		if any, leading to immediate  Cause. Enter Uniderlying Cause  Chicagos religing the individued  C.			
sit id	Examine	(Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):			
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Division of Vital Records, ral or Attending Physician: The law requirers after death.  al Director: After this certificate has been siled in by the funeral director, page 2 should be attitication.	ŏ	25. Was case referred to medical examiner?  1 Ves 2 No   Hospital: 1   Inpatient 2 V ER/Outpatient 3   DOA   Other   Nursing	g Home 5 1	Residence 6 Other	78-72
of V	- 1	27. Manner of Death  28a. Date of Injury (Month Day Year)  28b. Time of Injury 28c. Injury at Work?		ow injury occurred	
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ospi hou y fil		4 Homicide 29a. Certifier	due to the cause	a(e) and manner as state	ad.
Division of To the Hospital or Attending Physiph 24 hours after death.  To the Funeral Director: After to completely filled in by the funeral Director.	2	(Check only 1 Certriying Physician: 10 the best of my knowledge, death occurred at the time, date and place, and one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at and manner stated.			
H 2 H 2	Ě	29b. Signature and title of certifier 29c. License number		29d, Date signed (Mor	
		(Carbelle O.C.M.E.		February 2, 2011	
(X) V		<ol> <li>Name and address of person who completed cause of death (Item 23a)</li> <li>Laron Locke MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, M</li> </ol>	1D 21223		
Stat	e	Of Date State of the Control of the			
Registra	ır	FEB 09 2011 Server B. Aparl			

Legible.

Please Type or Print in Black amend #1 Per Phy G912 State of Maryland	<b>ack Indelible Ink.</b> / Department of H	Ensure All Cop ealth and Mental	ies Are Hygiene
	Certificate of E		Reg. No.

93.74 Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Year Ricahrd Wallace Shaw January 20 2011 7:30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 5179 Perry Rd Mt. Airy Carroll 8. Date of Birth (Month, Day, Year) July 25, 1927 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Months Days Hours Min. 1⊠M 2□ F 579-24-9669 83 Director Iowa Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ite Medical Exprired must be retified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director 1 ☐ Yes 2X No Carroll Mt Airy MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21771 5179 Perry Rd. 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Armed Forces? I⊠Yes 2 No 1945-1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2X No <u>م</u> If Yes, Give Year or Dates: Specify: 3 Widowed 4 Divorced 1946 Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry un 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+)  $\begin{array}{c} \text{Elementary/Secondary (0-12)} \\ 12 \end{array}$ machinist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Marjorie Miller Olen Cyrus Shaw ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nancy Shaw - wife 5179 Perry Rd; Mt Airy, MD 21771 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 21. Signature | Euneral Strate Licensee 22. Name and Address of Facility State Anatomy Board ade Director 655 W. Baltimore St; Baltimore, MD 21201 23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cau e (Final Physician ora ay 10 disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner ement Sequentially list conditions. cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed Exami sician and burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE for use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year Day 5 Other (specify) signed by the a d be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ (00 D 1 ☐ Yes 2 ☐ No 3≠ Probably 4 ☐ Unknown director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 ☐Yes 24 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home SAResidence 6 ☐ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

Certification: To After this 24 hours after death.

Funeral Director: After thi letely filled in by the funeral of

1. Natural

2 Accident

3 Suicide

4 ☐ Homicide

5 Pending

investigation

6 Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

1 ☐ Yes 2 ☐ No

mo 55/04

30. Name and address of person who pipleted cause of death (Item 23a) (Type, Print)

Gail Teresa Griffin Parkview Med. Group 1502 South Main ST MT. AIRY, MD 21771

State Registrar

completely

the within 7 Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death 3. Time of Death Day Year **Physician** alhoun hruan /Medical Town, or Location of Death give street and humber) 4c. County of Death 4b Examiner LILMO If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) (In vrs. last birthday) Sex Funeral Year) 1 M 2□ F Months Days Hours Jan 150-60-3553 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10h County ms 23a or 28a-f shov 28a-f shov 1 Yes 2 □ No **Funeral Director** altimore 10g. Citizen of What Country? 21229 305Wel 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) th and Mental Hygiene.
7 is marked other than "natural", or items traumatic event, tre Medical Evaninaria. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No 14. Race - American Indian, Black, White, etc Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 □Yes 2 No If Yes, Give Year or Dates: Specify Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) riciar 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Ma Be lauc ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) if of Health Boswell Road Department of Health Important: If item 27 any Injury or other tra 209 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 Removal from State 2-15-2011 Owings Mills, MD 4 ☐ Donation 5 ☐ Other (Specify) Jarrison 22 Name and Address of Facility Vaughn, C. Greene Fuperal Services 21. Signature of Funeral Service Ligar (21229) Baltimore National Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Atheroscieratic Coroner disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner robable Sequentially list conditions, if any, leading to initirediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine the burial-tran Due to (or as a consequence of) After this certificate has been signed by the attending physician funeral director, page 2 should be detached for use as the burial Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Únknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No 24a Was an autopsy performed? 1 Yes 2 100 this certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2 ⊠Ño 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation ue Hospital or Attend n 24 hours after death ie Funeral Director 2 ☐ Accident completely filled in by the 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Z Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only fo the I and manner stated. the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 7)50293 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOSPITAL, BACTIMERE, ST AGNET 0 9 2[ 2. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Brian Safer 11:40 PM February Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Hillhaven Nursing Center Adelphi If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min. Social Security Number . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months (Month, Day, Ye New York 094-34-6764 68 Dec. Director T942 Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD 1 Yes 2XX No Prince George's Adelphi 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 3210 Powder Mill Rd. 20705 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 L No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14 Bace - American Indian. Black, White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: If Yes, Give Specify: 3 Divorced 4 Divorced Year or Dates. Vietnam White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Medicine 5+ Scientist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ John Safer Shebanowitz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 555 S. Main St., Providence, RI Nancy D. Safer / Friend 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory: 2/8/2011 Beltsville, MD 21. Signatur Fun ral Service Livensee Rapp Funeral and Cremation Services 933 Gist Ave., Silver Spring, MD 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) CARDIORESPIRATORY ARREST Medical Due to (or as a consequence of) Examiner CEREBROVASUCLAR ACCIDENT sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) ATHEROSCLEROSIS signed by the attending physician and d be detached for use as the burial-trans the Hospital or Attending Physician: The law requires that the death certificate be execute that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 1 Yes 2 9 Unknown 2 🗌 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by PARKINSON"S DISEASE within 24 hours after death.

To the Funeral Director: After this certificate has been sit completed filled in by the funeral director, page 2 should I 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an DEMENTIA autopsy 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 JNo ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred XX Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 🛄 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State

DHMH 17 Rev 7/2009

Registrar

31. Date filed (Month, Day, Year)

FEB 0 9 2011

Zuniga, M.D.; 4701 Randolph Rd. #216, Rockville, MD

s of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signatur

D47867

February 7, 2011

20851

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ John Calvin Sherman, Sr. enth Cor 10:10A.M. 2017 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Glen Burnie 4c. County of Death Anne Arundel Examiner Baltimore Washington Medical Ctr If Under 24 Hrs. Hours Min. 5 Social Security Number If Under 1 Year 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 □**X**M 2 □ F 79 Months 236-46-6056 1277977937 West Virginia Director Usual Residence of Decedent items 23a or 28a-f shov 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at the Maryland Director 1 🗆 Yes 2XX No Maryland Anne Arundel Severn 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code by Funeral with United States 8321 Dubbs Dr. 21144 permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu once. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2XXNo 1 Never Married 2XX Married 1 Yes Specify Specify:White If Yes, Give 2 No 3 🗆 Widowed 4 🗆 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Exxon 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Truck Driver Be 17. Father's Name (First, Middle, Last) Richard Hesper Sherman 18. Mother's Name *(First, Middle, Maiden Surname)* Sylvia Ilette Kiser 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandra Elizabeth Sherman/Wife 8321 Dubbs Dr., Severn , Maryland, 21144 Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) ▼ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Memorial 2/7/2011 Elkridge, Maryland 22. Name and Address of Facility Gary L. Kaufman Funeral Home, Inc. 21. Signature of Funeral Service 7250 Washington Blvd.,Elkridge,Maryland,21075 se or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, but only one cause on sach line. 23a. Part 1. Enter the disea shock, or heart failure. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) unun Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury that initiated so or injury) Due to (or as a consequence or): attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year 5 Other (specify) Pregnant at time of death signed by the article by the article for the signal of the detached for the signal of g Unknown contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 1 Yes 3 Probably 4 Unknown Completed peen : 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an page 2 s autopsy After this certificate funeral director, pag 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ည 1 🗌 Yes Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Anner of D Natural Accid Date of injury (Month, Day, Year) 27. Manner of Dea 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 - Pending work? 2 No Investigation Accident within 24 hours after death

To the Funeral Director; / Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier 🔼 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie 29c. License number of person who completed cause of death (Item 23a) (Type, Print)

Registrar

( Year)

FEB

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For		State of M	larylan	-	artment of H		and M	ental Hy	giene	n 1 1		
			State Registrar				Cer	tificate of L	Death			Reg. No.		13479	
	Physicia	an/	Decedent's Name (First	t, Middle, Last)							<ol><li>Date of Dea Month</li></ol>	Dav	Year	3. Time of Death	
garage,	Medi	cal	Charles	Richa		Sill	S				Februa		2011	8:30A M	
	Examir	ner	4a. Facility Name (if not in	-				4b. City, Town, or		t Death			inty of Deatl	1	
1	Funeral		2417 Old En			Road, #A Abingdon  7. Age (In yrs. last birthday)   If Under 1 Year   If Under 24						h	rford 9. Birt	hplace (State or Foreign	
	Director		212-52-9560	1 🕅	M 2 🗆 F	60	) Yrs.	Months Days	Hours	Min.	(Month, Day 01/22/	1951	Cot	Country) Maryland	
	d t ow		Usual Residence of Deced 10a. State 10b.	dent County		140.00	-								
	nylan I-f sh ied a	Director		,			y, Town or Loc	eation						10d. Inside City Limits 1 ☐ Yes 2 ☒ No	
	or 28s	Fig	MD F 10e. Street and Number	Harford		Ab	ingdon	10f. Zip Code				10g. Citizen	of What Co		
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	eath v	Funeral	2417 Old En		. Was Decedent	Ever in U.S		21009 Vas Decedent of H	ispanic Orig	in? (Spec	ify Yes or No-		S.A.	ican Indian,	
9	ter de	ğ	1 Never Married 2	<b>☒</b> Married	Armed Forces?			Yes, specify Cuba		Puerto R	ican, etc.)	E	Black, White		
903	ursal tural" al Exa	ted	3 Widowed 4 C		If Yes, Give Year or Dates.			☐ Yes 2 🔀 No	Specify:			Spec	cify: Wh	nite	
21215-0036	72 hours after death with the Maryland n "natural", or items 23a or 28a-f sho fedical Examiner must be notified at	Completed		Decedent's Educ ally highest grade			(Give k	ent's Usual Occup ind of work done o		of workin	g	16b. Kind o	f Business I	ndustry	
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lan	should and I is ma		19a. Informant's Name/Re	elationship ( <i>Type,</i>	Print)		19b. Mailin	g Address (Street a	and Number	or Rural	Route Number	; City or Towi	n, State, Zip	Code)	
≥,	and 2		Victoria Si		ife			Old Emmo	orton	Road	, #A, A	Abingd	on, M	D 21009	
Ore	ge 1a st of H if ite or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cre		moval from State		lace of Dispos emetery, crem	sition (Name of atory or other plac	e)	Da	ate	20c. Location	on - City or	Town, State	
Baltimore,	it. Paç rtmer rtant njury		4 ☒ Donation 5 ☐			An		fts Regist			/2011			Maryland	
Ba	permit. Page 1 and 2 sho Department of Health an Important: If item 27 is any injury or other trau		21. Signature of Fundal S	Service Lice/is. e				Name and Addres							
			23a. Part 1, Enter the disc	ease, or complica	itions that cause	d the death							ver,	Approximate	
	Pnysician/	15 5	shock, or heart failur Immediate Cause (Final	re. List only one o	ause on each lin	e.	1	Donal	1:00					Interval Between Onset and Death	
	Medical		disease or condition resulting in death)	a.	Due to (or as	a consequ	ence of):	Dea	1100		2				
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	o d	nine	if any, leading to immedia cause. Enter Underlying	ate 2	Due lu (ur as	a consequ	erice oij.	P.			V				
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k 687	endin endin	an/l	IF FEMALE: 23b. Was decedent pregna	carre 1	If yes, outcome	of pregnar	ncy Lideath 3	Ectopic pregnanc	V			23d.	Date of deli	very	
Box	ne death certifica r the attending p ched for use as t	Physician/M	in the past 12 months 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	S'7	4 Pregnant a	at time of d	eath 5	Other (specify)	,				Month	Day Year	
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of	Attending Physician; Ther death. ector: After this certificath by the funeral director, p.	te:	27. Manner of Death  1 Natural 5	Pending	28a. Date of inju (Month, Da	ıry y, Year)	28b. Time of injury	28c. Injury work	at		3d. Describe ho				
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Division	I or Attendate after death Director.	١ŏ١	4 🗌 Homicide	determined	28e. Place of Injudently building, etc.	ury - At hor c. <i>(Specify)</i>	me, farm, stre	et, factory, office		2	Bf. Location (Si City or Town		mber or Run	al Route Number,	
	To the Hospital or Attentwithin 24 hours after deat To the Funeral Director: completed filled in by the	Medical	29a. Certifier 1 Ce	ertifying Physicia	n: To the best of	my knowle	edge, death o	ccured at the time,	date and p	lace, and	due to the cau	se(s) and ma	inner as stat	red.	
	he Ho in 24 he Fu plete	Med	(Check 2 ∐ Me	edical Examiner:	On the basis of e	examination	and/or investi	gation, in my opinic eath occurred at the	n, death occ	curred at t	ne time, date ar	nd place, and	due to the c	ause(s) and manner stated.	
	To the within 2 To the comple		29b. Signature and title of	certifier	00.0	,		29c. License	number	07	2	29d. Date sig	ned (Month,		
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_			30. Name and address of							D = 1	7) 3	חור חו	15		
	Stat	e	Dr. Joseph 31. Date filed (Month, Day,	Ange Io	32. Registra	ar's Signatu	untree	KOad, St	e, D,		AIL, I	אר אדר הוי	T.)		
	Registra		reb U 9 2	2011	wound,	13. 19	back								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month TIO (AM Aris 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Oakcrest Medical Center Balto. arkville 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗓 F Months Days Hours Min 9-2-1929 Mary Land Director 214-26-6992 81 Usual Residence of Decedent If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 72 hours after death with the Maryland Director 10c. City. Town or Location 10d. Inside City Limits 1 Yes X No Md. Balto. Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral USA 8810 Walther Blvd 21234 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?
1 Yes 2 No Black. White, etc. 1 ☐ Never Married 2 🛚 Married 21215-0036 White 1 ☐ Yes 2 No Specify: If Yes. Give Specify 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) be filed within Homemaker Home Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Marie Maseth William Morgan Page 1 and 2 should f Health and Nitem 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8810 Walther Blvd. Parkville, Md. 21234 August Thiel Spouse Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o 1 Denial 2 Cremation 3 Removal from State cemetery, crematory or other place, 2-8-2011 Donation 5 Other (Specify) Highview Fallston, Md. Signature of Funeral device Licensee 22. Name and Address of Facility Schimunek Funeral Home hun 9705 Belair Road Nottingham, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) uro sep 115 Medical Due to (or as a consequen Examiner emunta Sequentially list conditions, if any, leading to immediate cause. Eleas or injury Examine Due to (or as for use as the burial-transi that initiated events signed by the attending physician and resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Division of Vital Records, P.O. Box 3 Ectopic pregnancy in the past 12 months

1 Yes 2 No 5 Other (specify) Pregnant at time of death Month Day Year 1 ☐ Yes ∠ ₩ 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an after death.

Director: After this certificate has autopsy performed? 2- No 1 Yes 25. Was case referred to medical Be ( 26. Place of Death (Check only one) examiner? Hospital: Other: 1 Tes 2 No ြု 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work?
1 
Yes Certificate: 5 Pending injury Natural 2 No Accident Investigation filled in by the 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined within 24 hours a To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only on 29b. Signature 29c. Lie 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 7/2009

12

State

Registrar

name and address of p

31. Date filed (Month, Day, Year,

9

rson who complete

800

wether B(U)

ed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

			Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.  Amend Item 25 per me, g916,06/03/2011dhb State of Maryland Department of Health and Mental Hygiene State State Registrar  Amend Item 26 per veb.,g912,02/09/2011dhb Certificate of Death Reg. No.
	Physicia		1. Decedent's Name (First, Middle, Last)  ANGE  THOMPSON  2. Date of Death  Sont No.  3. Time of Death  Sont No.  2. Date of Death  Sont No.  3. Time of Death  Sont No.
	Medic Examir		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 MF 7. Age (In yrs. last birthday) 1 M 2 MF 7. Age (In yrs. last birthday) 4. Social Security Number 1 M 2 MF
	ryland I-f show ied at	ctor	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits  10
	/ith the Ma 23a or 28a st be notif	Funeral Director	10e. Street and Number  5807 Clover Road  10f. Zip Code 21215  10g. Citizen of What Country?  USA
980	ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene.  If of Health and Mental Hygiene.  If fire Z7 is marked other than "natural", or items 23a or 28a-f show if it in 27 is marked other than "natural", or items 2 be notified at or other traumatic event, the Medical Examiner must be notified at	þ	11. Marital Status  1
215-0	thin 72 hou sne. than "natu ne Medical	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Seconday (0-12)  College (1-4 or 5+)  College (1-4 or 5+)  College (1-4 or 5+)
ınd 21	e filed within rtal Hygiene. ed other thai event, the N	To Be C	17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Surname)
Maryland 21215-0036	2 should be file  Ith and Mental   27 is marked c  r traumatic eve		William Riddick  Allonia Johnson  19a. Informant's Name/Relationship (Type, Print) (Husband) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  Wenzo J. Thompson 5807 Clover Road Baltim One MD 21215
nore, l	Page 1 and 2 ment of Healt ant: If item 2 ury or other		20a. Method of Disposition  20b. Place of Disposition (Name of Date 20c. Location - City or Town, State
Baltimore,	permit. Page 1 a Department of I Important: If ite any injury or ot once.		4 Donation 5 Other (Specify)  21. Signature of Funeral Service Services  22. Name and Address of Facility Vaugan C. Green Fun and Services
ı			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line.  Immediate Cause (Final Onset and Death)
	mysiciam Medical Examiner		Immediate Cause (Final disease or condition resulting in death)  Onset and Death  Due to (or as a consequence of):
	red nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury
	e be executed ysician and e burial-transit	I	Cause (Disease or injury that initiated events resulting in death) Last  C.  Due to (or as a consequence of):  d.
. Box 68760	To the nospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the bu		FFEMALE: 23b. Was decedent pregnant in the past 12 mopths?   1
s, P.O.	ures tnat tr signed by Id be deta	d by Pł	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?  1   Yes 2   No 3   Probably 4   Unknown
Division of Vital Records,	ne iaw requ te has beer age 2 shou	Completed by	24a. Was an autopsy findings available prior to completion of cause of death?
italF	'sician: The law s certificate has t lirector, page 2 s	Be	25. Was case referred to medical examiner?  1 X Yes 2 No  26. Place of Death (Check only one)  Hospital: X Inserticat 3 PRO Other:
of V	ding Physician: The lath. After this certificate he funeral director, page.	ate: To	27. Manne of Death  28b. Date of injury  (Month, Day, Year)  28b. Time of injury work?  28d. Describe how injury occurred work?
ivision	or Attency after death Director: A I in by the	Certificate:	2 Accident 3 Sulcide 6 Could not be determined
<u>.</u> :	le nospira n 24 hours le Funeral pleted fillec	Medical	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
	withii To th		29b. Signature and title of certifier Costa MD 29c. License number 29d. Date signed (Month, Day, Year) 30, 2011
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
	Stat Registra	~	B1. Date filed (Month, Day, Year)  FEB 0 9 2011  A 32. Registrar's Structure parks

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ US PM Medical 4a. Facility Name (if not institution, give street and number) Examiner Town, or Location of Death 4c. County of Death Baltimore nan If Under 1 Year If Under 24 Hrs Birthplace (State or Foreign Country) **Funeral** Age (In yrs. last birthday) 8. Date of Birth 216-90-544 1 🗆 M 2 🖫 42 Jonth, Day, Y Director Usual Residence of Decedent 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director ral", or items 23a or 28a-f s Examiner must be notified Raltimore 1 Yes 2 No 10e. Street and Number 10a, Citizen of What Country? Funeral 2/2/6 2328 Hvenue 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. Never Married 2 ☐ Married Completed by ☐ Yes 2 ❤️No Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 10 Specify: "natural", 3 Widowed 4 Divorced Black Year or Dates if Health and Mental Hygiene. item 27 is marked other than "natur other traumatic event, the Medical 16a. Decedent's Usual Occupation
Give kind of work done during most of working
Yim DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Secorday (0-12) College (1-4 or 5+) Decr Be Ther's Name (First, Middle, Last) Informant's Name/Relationship (Type, Print MD 21216 oraves 20a. Method of Disposition Place of Disposition (Name of Location - City or Town, State ō Important: If it any injury or o or other place) 1 Burial 2 Cremation 3 Removal from State cemetery, cremator 4 ☐ Donation 5 ☐ Other (Specify) f Funeral Service Licensee Nº Ces 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) e to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence or) To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and I for use as the burial-transi Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Unknown been signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autonsy perform Director: After this certificate 1 Yes 2 No Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 2 No 1 🗌 Inpatient 2 🗌 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 3 Suicide 5  $\square$  Pending injury 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number City or Town, State) within 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print 9 31. Date filed (Month, Day, Year) FEB 0 9 2011 Registrar's Si State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 0815 2011 ATHRYN Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Annapolis Anne Arundel Med If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign Funeral Min. 1 M 2 F Hours 66 (Month, Day, Year) Crowa 484-52-8334 1944 Director Usual Residence of Decedent "natural", or items 23a or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shom any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel 1 Yes 2 No Severna Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4 River Drive 21146 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 ☐ No Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No Specify: If Yes, Give Year or Dates White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Computers Consultant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Davidson Watson Lucielle Sherman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 42576 19a. Informant's Name/Relationship (Type, Print) Shawn Wells /Son Magellan Square Ashburn, VA 20148 Priysicia Medic Examin

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760

Baltimore, Maryland 21215-0036

		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Removal from State   cemetery, crematory or other place)   Feb Up,	cation - City or Town, State  Beltsville, Maryland
ouce		21. Signature of Funeral Service Licens	22. NanGrennatchcomFannd Funeral Alternate Rotte Tow	
n,	ì	23a. Part 1. Enter the disease, or composition, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a consequence of):	Approximate Interval Between Onset and Death
er	Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	b. END STAGE COPD  Due to (or as a consequence of):  Due to (or as a consequence of):  d.	YEARS
(A) a ciciona	Iysician/iwe	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9  Unknown	23c. If yes, outcome of pregnancy  1  Live Birth 2  Fetal death 3  Ectopic pregnancy  4  Pregnant at time of death 5  Other (specify)	23d. Date of delivery Month Day Year
	Completed by Pr	Part II. Other significant conditions or		se contribute to the cause of death?
1			24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No	24b. Were autopsy findings available prior to completion of cause of death?  1  Yes 2  No
á	8	25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
- [2	2	1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6	Other (Specify)
Contification	ilcate:	27. Manner of Death  1  Natural 5  Pending 2  Accident Investigation 3  Suicide 6  Could not be	28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at work? 1 \( \text{Yes} \) 2 \( \text{D} \) No	
100		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and City or Town, State)	l Number or Rural Route Number,
Modical	Medica	(Check 2 Medical Exami	ician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and the cause of examination and/or investigation, in my opinion, death occurred at the time, date and place, a Praction of the best of my knowledge, death occurred at the time, date and place, and due to the cause(s)	and due to the cause(s) and manner stated.
	4	29b. Signature and title of certifier	29c. License number 29d. Date	esigned (Month, Day, Year) Ebruary 052011
		30 Name and address of person who c	ompleted cause of death (Item 23a) (Type, Print) ) EFE NSE Hwy ANN, a FEN W M YYF ) EFE NSE Hwy ANN,	APOLI M'DUYUI

DHMH 17 Rev 7/2009

State

Registrar

ICHAEL 31. Date filed (Month, Day, Year)

FEB 0 9 2011

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Dav Year 4:30 AM Ronald Weaver Medical February 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Stella Maris at Mercy Hospital Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Yea Dec 29, If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Days 1 M 2 D F Months Hours Year) Director 71 Yrs 216-36-1618 1939 Maryland Usual Residence of Decedent show 10a. State 10b. County death with the Maryland the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 28a-f 1 Yes 2 No MD Baltimore Baltimore 10e. Street and Number ŏ 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 538 Anneslie Road 21212 United States 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No
If Yes, Give
Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 0 þ 1 Never Married 2 Married hours after 1 ☐ Yes 2 ☐No Specify. "natural", Specify. Completed 3 Divorced 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) other t 1 Agent Insurance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fis marked o ပ္ permit. Page 1 and 2 should be Department of Health and Ment Important; If item 27 is marke any injury or other traumatic eonce. injury or other traumatic Earl Weaver Norma Mvers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan Weaver /Wife 538 Anneslie Road Baltimore, MD 21212 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Feb 07 4 ☐ Donation 5 ☐ Other (Specify) Beltsville, Maryland Chesapeake Crematory 2011 21. Signature of Funeral Service Licensee M01443 22. Name and Address of Facility Cremation and Funeral Alternatives 8717 Green Pastures Drive Towson Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) requires that the death certificate be execute physician and s the burial-trans resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Pregnant at time of death Day Year 2 🗆 No 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tyes page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law certificate has autopsy 1 🗌 Yes completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 🗆 Yes 2 No Other: 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Spec. After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury 2 No 1 Tes Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Contrying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2 To the 29b. Signature ap 29c. License number 0 ss of person who completed cause of death (Item 23a) (Type, Print) 2300

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

### Pleas

se Type or Print in Black Indelible Ink. Ensure All Copie	es Are Legible.	,
State of Maryland / Department of Health and Mental H	lygiene 2011 03485	,

		1- For State Registrar				Certifi	cate of	Dea	th			F	Reg. No			
Physicia		Decedent's Name (First, N	liddle,La	ıst)							2	2. Date of De	ath			3. Time of Death
Medical Exami	ıer	Vanessa White										Month January	Day 31, 20	Yea )11	r	1010 hrs
		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death								of Death	, , ,		c. County o	f Death		
		1615 Joplin Street						Balti	imore					n/	'a	
Funeral		5. Social Security Number	6. 8	Sex	7. Age (	In yrs. last b	irthday)	If Und	der 1 Year	If Unde	r 24Hrs.	8. Date of B	irth (MN	/DD/YYYY	9. Birt	hplace (State or
Director		212-70-1698	4	M 2X F		53		Mont	ths Days	Hours	_	09/30,	•		Foreia	
1	H	Usual Residence of Deceder					Yrs.					03/ 30/	13			——————————————————————————————————————
Amy	H	10a. State 10b. Cou			110	C. City, Tow	n or Location	on .	-						_	10d. Inside City Limits
			/													1 Yes 2 No
Maryland 28a-f show 1 at once.	힑	10e. Street and Number	n/	<del>a</del>	L		Balt									
Mar.	Director		¬					10f. Zi	ip Code	_			10g. Cii	izen of Wh	at Cour	ntry?
eath with the Maryland items 23a or 28a-f abo ust be notified at once.		1615 <b>J</b> oplin 9	otre	et					21224	4				USA		
h wit	Funeral	11. Marital Status  1 Never Married 2	7	12. Was De Armed F		er in U.S.			dent of Hispa			cify Yes or N	o-	14. Race White		can Indian, Black,
or ite	틹			1 Yes	2 🗙	No					1 delle IX	iodii, cic.)		VVIII.CO	Bla	ack.
after	<u>ā</u>			d If Yes, Give Ye or Dates:			1	Yes 2	2 X No :	specify:				Specify:	Dic	
5-0036 led within 72 hours afte Hygiene. l other than "natural", the Medical Examiner		15. Decedent's Education (							I Occupation orking life. D				16b.	Kind of Bus	iness/I	ndustry
6 1 72 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1	Completed	Elementary/Secondary (0-	12)	College (	1-4 or 5+)		-					,	1			
Arthur SO	힐	12				Ce	rtifi	ed I	Nursir	ng As	ssist	ant	He	ealth	Car	`e
Hygin Hygin		17. Father's Name (First, Mid	dle, Las	t)								First, Middle,				
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than ic event, the Medica	8	Arthur Ottway										Helen				
Ore, MD 21215-0036 ss I and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f ahe traumatic event, the Medical Examiner must be notified at once	의	19a. Informant's Name/Relati				10						ral Route Nu			, State,	Zip Code)
MD id 2 shoulth and in 27 is		Andre Arter-H	Husb	and								imore,				·
F. Hear Fire	- 1	20a. Method of Disposition  1 X Burial 2 Crema	tion 2	Domewal for	om Ctata		of Disposit atory or othe		ame of cemer	tery,	I	Date	20c.	Location -	City or	Town, State
Pages ent of	- 1	4 Donation 5 Other				arris	-			Cem	02.10	0.2011	low	inas l	Mill	s.MD
Baltimore, permit. Pages I an Department of He Important: If ite	ŀ	21. Signature of Funeral Serv					22. Na	me and	d Address of	Facility						
Baltimore, MD 21215 permit. Pages I and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked o injury or other traumatic event, th		told what	~	7								neral				
Physician	┪	23a Part I. Enter the disease	, or com	plications that c	aused the	death. Do r	not enter the	mode	of dying, su	ch as ca	AVE F	Baltime espiratory an	est, sh	MD 3	rt	Approximate Interval
(Medical		failure. List only one cau		ach line. . <b>Hypertensi</b>	vo Atho	rondorot	ic Cardio	vecul	lar Dinas							Between Onset and Death
Examiner		Immediate Cause (Final disea or condition resulting in death		Due to (or as a			ic Gardio	vscui	iai Diseas	Se					-	
	1	Seguentially list conditions	b			,										
	힐	Sequentially list conditions, if any, leading to immediate		Due to (or as a	consequ	ence of):										/
	mine	cause. Enter Underlying Cau (Disease or injury that initiate														
cuted und transit	<u> </u>	events resulting in death) La	st .	Due to (or as a	consequ	ence of):										
			— <sup>°</sup>													·
760, cate be ex physician the burial	/Medical	UNPENDED	-	AMENDED				_								
ficate be	ŠΙ	IF FEMALE: 23b. Was decedent pregnant i	n the	23c. If yes,		of pregnancy			2 🗆	C-4:-	pregnanc		23	d. Date of d		. v
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Divis  To the Hospital or A within 24 hours after To the Funeral Dire			xamine	r: On the basis of		ation and/or	investigatio	n, in my	y opinion, de	eath occ	urred at th	e time, date	and pla	ice, and du	e to the	cause(s)
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<b>√</b>		Melissa Brassell, Mi		ssistant Me		,	900 W	Baltin	nore Stre	et. Ba	ltimore	MD 2122	23			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ €55€ 1 0400 Februar 12:02 Medical 4a. Facility Name (if not institution, give street and number) Examiner City, Town, or Location of Death 4c. County of Death Ro 723W HT264 It CEBITAL ndallstow Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign M 2 🗆 F Months Days 216-36-319 comery land Director Yrs Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD 1 🗆 Yes 2 No Windsor 10e. Street and Number 10g. Citizen of What Country? Funeral 21244 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: 13 acl Completed 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Nachinz Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) C. Wine Sor Mil ZITE 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other pla Feb, 11, 2011 MI) 4 ☐ Donation 5 ☐ Other (Specify) ovellance metery Was ((Cun) 21. Signature of Funeral Service Ligensee Finera 450 270 FR ED Hutan mald 4 21220 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Atherosclerotio disease or condition resulting in death) Arter econory Medical Due to (or as a consequence of) Examine Esquentiany list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): the Hospital or Attending Physician; The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Yes \_ Unknown Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? s certificate has b lirector, page 2 st 24a. Was an autopsy perform 1 🗌 Yes Yes Be 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) examiner? ျ 1 Tes Other: ER/Outpatient 3 DOA After this 1 Inpatient 2 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work?
1 Yes 2 🗌 No Accident Investigation within 24 hours after de To the Funeral Directo completed filled in by th Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying fourse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifu 29d. Date signed (Month, Day, Year) 2011

State Registrar

DHMH 17 Rev 7/2009

ROAD

Registrar's Signature

Rendall Stown

21133

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

OUN

31. Date filed (Month, Day, Year)

FEB

09

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/  $0^{Month}$ 06 2011 8:00 AM Meridias Ozell Young Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Hospice Timonium Baltimore Social Security Number If Under 1 Year If Under 24 Hrs **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 - M 2 K F Months Days Hours Min. (Month, Day, Year) 07-28-1920 230-26-9603 South Carolina Director 90 Usual Residence of Decedent 28a-f shov 10a State 10b. County 10c. City, Town or Location must be notified at Director 10d. Inside City Limits MD Baltimore 1 X Yes 2 No ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 1432 Stonewood Road 21239 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. "natural", or iter Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Saltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Completed 3X Widowed 4 ☐ Divorced Specify: Black Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry continental can Je filed win. -\*al Hygiene. 'Ser than "r (Specify only highest grade completed) Elementary/Seconday (0-12) 7th College (1-4 or 5+) the of Health and Mental Hygie item 27 is marked other other traumatic event, the Can Food Processer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Roland Brunson Mariah Segars 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Sara Ash (Daughter) 1432 Stonewood Rd, Baltimore MD 21239 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. Stanislaus Date 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🔲 Removal from State 2/19/2011 Dundalk, MD 4 Donation 5 Other (Specify) uneral Service Licenses 22. Name and Address of FacilityPhillip A. Weatherford F.S. 2431 E. Oliver Street, Baltimore MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final CEREBRO VASCU Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or linjury Jue to for as a don sequence of, attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Day Year 1 ☐ Yes 2 µ 9 ☐ Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown Records, 1 Tes MARIE VA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performe Physician: The 2 🗆 No Yes 2 No 1 🗌 Yes Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 X No Other: ၉ 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE 1 Inpatient 2 ER/Outpatient 3 DOA After this Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 Natural 2 Accident injury 5 Pending 1 ☐ Yes 2 ☐ No after death Investigation the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie (Check Certifying Nurse Practioners To the best of my knowledge, doesn occurred at the time, date and place and due to the 29b. Signature and title 30. Name and address of son who completed cause of death (Item 23a) (Type, Print) State Registrar DHMH 17 Rev 7/2009

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10	_1	Carol Allan, M	ID Ass	istant Medical Exa	miner 90	0 W. Bal	Itimore St	treet,	Baltimo	re, MD	21223				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 1 tem 27 per me 912 2-24-11 vt State of Maryland / Department of Health and Mental Hygiene 2 03490 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month L Huder Year 201 isan CU Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore zuuna . Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birtholace (State or Foreign **Funeral** 1 □ M 2 🏻 F Months Days Hours Min. AUG. 30, 1952 Virginia 216-58-6126 Director 58 Usual Residence of Decedent 28a-f show 10a. State 10b. County with the Maryland 10c, City, Town or Location be notified at 10d. Inside City Limits Director 1 X Yes 2 □ No Maryland Frederick Frederick 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? er than "natural", or items 23a the Medical Examiner must be Funeral 1421 Taney Ave./ Apt. 216 21702 United States within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married by Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🛛 No Specify: White 3 Widowed 4 X Divorced Specify: Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 th and Mental Hygiene.
77 is marked other than "; Elementary/Seconday (0-12) 12 College (1-4 or 5+) bartender hospitality service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Norman Anders Dorothy other traumatic Voith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 shr.
Department of Health an
Important: If item 27 is
any injury or other trau Cathleen L. Smith /sister Navaho Dr./ Frederick, Maryland 21701 Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Jan.24,2011 Stauffer Crematory Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike/Frederick, Maryland 21702 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. nterval Between Onset and Death Immediate Cause (Final Physician/ Fulminant disease or condition resulting in death) ne welk Medical Due to (or as a consequence of): Examiner hoses Marine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) ohysician and the bunal-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last BEONED BY WEDICAL Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day cate has been signed by the a page 2 should be detached it 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performe death?
1 Yes 2 Yo Yes 2 No To the Funeral Director: After this certifics completed filled in by the funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 10 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury ☐ Natural 5 Pending 2 Accident Tall unknum 1 Yes Investigation 3 Suicide 4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital or within 24 hours a To the Funeral D unknow UNKNOWN Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signatore and title of certifie 29c. License number NFI 180 102 1456 n who completed cause of death (Item 23a) (Type, Print) address of pers Paltmin 31. Date filed (Month, Day, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 10:40a M Thomas Joon Ahn Januaru 011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery 2007 Birthday Court Brookeville 5. Social Security Number 9. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday 8. Date of Birth 1 🗶 M 2 🗆 F Months 10707/1934 Director 245-78-6957 76 Korea Usual Residence of Decedent show 10a. State 10b County items 23a or 28a-f sho ner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland Brookeville Montgomeru 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funera 2007 Birthday Court 20833 U.S.A. death v 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. "natural", or þ 1 Never Married 2 X Married 1 ☐ Yes 2 🕱 No If Yes, Give Baltimore, Maryland 21215-0036 72 hours after 1 ☐ Yes 2 X No Specify. Completed 3 Widowed 4 Divorced Asian Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Minister Church Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Kyung Yong Ahn Tae Soon Kim 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sally Young Ahn - Spouse 2007 Birthday Court. Brookeville. Maryland 20833 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Description | 2 Cremation | 3 Removal from State | 4 Donation | 5 Donation | 5 Donation | 5 Donation | 5 Donation | 5 Donation | 5 Donation | 5 Donation | 5 Donation | 5 Donation | 5 Donation | 5 Donation | 5 Donation | 5 Donation | 5 Donation | 5 Donation | 5 Donation | 5 Donation | 5 Donation | 5 Donation | 5 Donation | 5 Donation | 5 Donation | 5 Donation | 5 Donation | 5 Donation | 5 Donation | 5 Donation | 5 Donation | 5 Donation | 5 Donation | 5 Donation | 5 Donation | 5 Donation | 5 Donation | 5 Donation | 5 Donation | 5 Donation | 5 Donation | 5 Donation | 5 Donation | 5 Donation | 5 Donation | 5 Donation | 5 Donation | 5 Donation | 5 Donation | 5 Donation | 5 Donation | 5 Donation | 5 Donation | 5 Donation | 5 Donation | 5 Donation | 5 Donation | 5 Donation | 5 Donation | 5 Donation | 5 Donation | 5 Donation | 5 Donation | 5 Donation | 5 Donation | 5 Donation | 5 Donation | 5 Donation | 5 Donation | 5 Donation | 5 Donation | 5 Donation | 5 Donation | 5 Donation | 5 Donation | 5 Donation | 5 Donation | 5 Donation | 5 Donation | 5 Donation | 5 Donation | 5 Donation | 5 Donation | 5 Donation | 5 Donation | 5 Donation | 5 Donation | 5 Donation | 5 Donation | 5 Donation | 5 Donation | 5 Donation | 5 Donation | 5 Donation | 5 Donation | 5 Donation | 5 Donation | 5 Donation | 5 Donation | 5 Donation | 5 Donation | 5 Donation | 5 Donation | 5 Donation | 5 Donation | 5 Donation | 5 Donation | 5 Donation | 5 Donation | 5 Donation | 5 Donation | 5 Donation | 5 Donation | 5 Donation | 5 Donation | 5 Donation | 5 Donation | 5 Donation | 5 Donation | 5 Donation | 5 Donation | 5 Donation | 5 Donation | 5 Donation | 5 Donation | 5 Donation | 5 Donation | 5 Donation | 5 Donation | 5 Donation | 5 Donation | 5 Donation | 5 Donation | 5 Donation | 5 Donation | 5 Donation | 5 Donation | 5 Donation | 5 Donation | 5 Donation | 5 Donation | 5 Donation | 5 Donation | 5 Donation | 5 Donation | 5 Donation | 5 Donation | 5 Donation | 5 Donation | 5 Donation | 5 Donation | 5 Donation | 5 Donation | 5 Donation | 5 Donation | 5 Do cemetery, crematory or other place Gate of Heaven Cem. 101/27/2011 | Silver Spring, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. Neva M. 11800 New Hampshire Ave., Silver Spring. MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Chrysician, Gastric Carcinoma disease or condition years Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): an and Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or imjury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Year Pregnant at time of death 2 No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed e Funeral Director: After this certificate I leted filled in by the funeral director, pag Yes 2 X No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: ᅆ 1 ☐ Yes 2 🕱 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🗷 Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred X Natural 5 Pending Accident
Suicide 1 🗆 Yes 2 🗆 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral D 29a, Certifier 🕱 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one d title of signed (Month, Day, Year) Dh81160 rson who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

Registrar

Peter Hauser,

31. Date filed (Month, Day, Year)

22 South Green Street, Baltimore,

Mal Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra MEND#7perFH, 1/26/11; BMW, McCo Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Alston **Physician** Month 0 OH /Medical an. OM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MCK anham Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs last birthday 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2 👿 F 93 Yrs. 77-60-7479 Director Virginia ian-8th. Usual Residence of Decedent Pages 1 and 2 should be filled within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10a. State 10b. County items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director 1 Yes 2 No DC Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2111 S Street NE Funeral [ 20002 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2♣No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Batimore, Maryland 21215-0036 or, If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ XNo b Specify: Specify: 3X Widowed 4 ☐ Divorced Black "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than " Elementary/Secondary (0-12) 10th College (1-4or 5+) permit. Pages 1 and 2 should be filled with Department of Heatth and Mental Hygiens Important: if item 27 is marked other that any lujury or other traumatic event, Inagonee. Currency Examiner Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Peter Louis Kinney ပ Rosa Wheeler 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2108 T St. SE <u>Deborah Dickerson/Niece</u> Washington, DC 20020 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Lincoln 1/27/2011 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 3831 Georgia Ave. NW Washington DC Washington, cc0278 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** aavanc disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any least in the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dust to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician Physician/Medical the as attending IF FEMALE: for use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?

1 Yes 27 No
9 Unknown Month Day Year 5 Other (specify) detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Known Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy nerform certificate 1 ☐ Yes 202 1 ☐ Yes completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 Tes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this O 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of within 24 hours after death.

To the Funeral Director: After 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 29a. Certifier rtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the sasis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title o 29c. License number 29d. Date signed (Month, Day, Year) D0062885 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) P.O. BOX 8442 RESTON. SONTA

DHMH 17 Rev 1/2001

State

Registrar

Day Year)

32 Registrar's Signature

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Dep		/lental Hygi	ene						
			Registrar Ce	rtificate of Death	Re	Reg. No. 2 1 1 3 1						
	Physicia	n/	1. Decedent's Name (First, Middle, Last)		Date of Death     Month	Dav Year	3. Time of Death					
	Medic		Pauline Allen  4a. Facility Name (if not institution, give street and number)	1	Januar	ary 22,2011 10:15AM						
	Examin	er	Genesis Eldercare Center	4b. City, Town, or Location of Death  La Plata		4c. County of Dea						
	Funeral		5. Social Security Number 6. Sex 7. Age (In vrs. last birthday)	If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Charle 9. Bir	thplace (State or Foreign					
	Director		579-26-6772 1 M 2 X F 88 Yrs.	Months Days Hours Min.	(Month, Day, Y 4 / 15 / 1	(ear) Co	Georgia					
	, mo		Usual Residence of Decedent									
	yland -f sh ed a	ctor	10a. State 10b. County 10c. City, Town or Lo	cation			10d. Inside City Limits					
	e Mar r 28a notifi	Jire	Md. Charles Waldorf				1 X Yes 2 No					
	ith th	rall		10f. Zip Code	10	g. Citizen of What Co	ountry?					
	ath w	<b>Funeral Director</b>	10707 Cedarwood Drive  11. Marital Status 12. Was Decedent Ever in U.S. 13.	20601 Was Decedent of Hispanic Origin? (Spe	oify Ves or No-	USA 14. Race - Ame						
ထ	within 72 hours after death with the Maryland glene. er than "natural", or items 23a or 28a-f sho er the Medical Examiner must be notified at , the Medical Examiner must be notified at	by F	Armed Forces?  1 □ Never Married 2 □ Married 1 □ Yes 2 ☒ No	If Yes, specify Cuban, Mexican, Puerto		Black, Whit						
8	rs aft ıral", IExa	pa	3 ☐ Widowed 4X☐ Divorced If Yes, Give Year or Dates.	1 ☐ Yes 2 🔀 No Specify:		Specify: B1	ack					
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aŭ	be file	입	Johnny Williams	Sallie		Maiden Surname)						
ᇫ	12 should be filed vaith and Mental Hyg 27 is marked other r traumatic event,			lity or Town State 7i	n Code)							
ž	12 shalth a		Tob. Mail	ng Address (Street and Number or Rura 7 Cedarwood Dr.			•					
ē,	1 and of Heal item,		20a. Method of Disposition 20b. Place of Disp	osition (Name of		0c. Location - City or						
Ĕ	Page 1 nent of ant: If it ury or o			matory or other place)	/2011 R	iverdale	Μđ					
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.			2. Name and Address of Facility B1	uford F	uneral S	ervice					
<u> </u>	89 = 89	T)	* Chrylle D. Blufos 2	019 Martin Luth	er King	Ave.,Wa	sh. 20019					
			23a. Part 1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line.				Approximate Interval Between					
-5	Pnysician/	17	Immediate Cause (Final disease or condition Em Store rend	al Poilure		(5)	Onset and Death					
	Medical Examiner		Due to (or as a consequence of):	1201 00								
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	red	Examiner	cause. Enter Underlying Cause (Disease or ilinjury									
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09	law requires that the death certificate be executed nas been signed by the attending physician and a 2 should be detached for use as the burial-transit	edical	d									
_	tificat ng ph as th	Mec	IF FEMALE:									
Box 68	ath certifica attending p	ian/	23b. Was decedent pregnant in the past 12 morths?  23c. If yes, outcome of pregnancy  1 □ Live Birth 2 □ Fetal death 3	Ectopic pregnancy		23d. Date of de	-					
	deat the at ned fo	Physician/M	1 ☐ Yes 2 No 4 ☐ Pregnant at time of death 5 ☐ 9 ☐ Unknown	Other (specify)		Month	Day Year					
o.	requires that the de been signed by the should be detached	F.	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e Did toba	cco use contribute to	the cause of death?					
S,	signe d be o	d b		, 0	1 \( \text{Yes}		robably 4 🗆 Unknown					
ord	requ	lete			24a. Was an		topsy findings available					
Records,	e has	Completed			autopsy performe	prior to death?	completion of cause of					
24a. Was an autopsy performed to death?  1												
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<u>o</u>	tendii leath. or: A: the fu	iţice	2 Accident Investigation 3 Suicide 6 Could not be	M 1 ☐ Yes 2 ☐ No								
Division of	or At	Certificate:	4 Homicide determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)	eet, factory, office	28f. Location (Stree City or Town, S	et and Number or Ru. State)	ral Route Number,					
Ξ	ours seral [		1 -1 1 1	( )	у!							
	To the Hospital or Attending Physiciam: within 24 hours after death.  To the Funeral Director: After this certific completed filled in by the funeral director,	Medical	29a. Certifier (Check only one)  2 Certifying Physician: To the best of my knowledge, death 2 Medical Examiner: On the basis of examination and/or investoring Nurse Practioner: To the best of my knowledge,	tigation, in my opinion, death occurred at	the time, date and i	place, and due to the	cause(s) and manner stated.					
	d. Date signed (Month											
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	200		30. Name and address of person who completed cause of death (Item 23a) (Type, I	Print)	1- 00	710						
1	(R 2-		2007 Tidewoter Chony Dr. Suit	10000UX 1 X 1 S	is im	D 2140	1					
	State Registra		31. Date filed (Month, Day, Year)  JAN 2 6 2011  32. Postrar's Signature	mel			,					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 1740 Rudolph William Arena Medical 2011 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Hicamier SAUSDIN Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Ars 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Days Hours XX M 2 D F 11/26/1926 Country) Director 84 198-20-0370 Usual Residence of Deceden 28a-f show 10a. State ral", or items 23a or 28a-f sho Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 🧎 No MD Worcester Berlin 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 58 Bird Nest Dr. 21811 "natural", or items within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2X Married 1 X Yes Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced Completed Specify: White Year or Dates. the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 16b. Kind of Business Industry (Specify only highest grade completed) marked other than life DO NOT use retired) Elementary/Seconday (0-12) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important, if item 27 is marked other that any nijury or other traumatic event, the Mones. College (1-4 or 5+) Federal Gov. rector/ IRS Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Arena Anna DeRosa 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Vita R. Arena</u> Bird Nest Dr. Berlin, MD 21811 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) entombment Springhill Mem. Gardens 1/29/11 Hebron, MD 22. Name and Address of Facility The Burbage Funeral Home 108 William St. Berlin, MD 21811 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final M Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner CEDO 3044S ADRIC JA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and STENDERS YELLS ASRIK Due to (or as a consequence of) resulting in death) Last the attending physician a hed for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) signed by the atter in the past 12 months? Month Pregnant at time of death Day Year 9 | Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by WESTERIANCE 1 Yes 2 No 3 Probably 4 WUnknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Hospital Other: ျာ 1 Tes 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. dical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one Ying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) 22 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BA 10+1 Salisbury MD 2184 ames 3 001 Comoli 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 5 ner fh 9914 4-11-11 vt. State of Maryland Poepartment of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Mollie B. Avrut 13, 2:05 p Jan<u>uary</u> 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Bedford Court Assisted Living Silver Spring Montgomery 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 06/17/1922 579-14-0648 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 🗆 M 2X 🗀 F Min. New York Director Yrs <del>119-01-5403</del> 88 Usual Residence of Decedent or 28a-f shov notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 K Yes 2 No MD Montgomery Bethesda 10e, Street and Numbe must be n 10f. Zip Code 10g. Citizen of What Country? Funeral 10110 Ashburton Lane <u> 20817–1730</u> USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Black, White, etc. ö þ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give White 1 ☐ Yes 2 X No Specify: Specify: "natural" 3 XWidowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ရ Morris Boker Sarah Horwitz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gail Caslani, daughter 10110 Ashburton La, Bethesda, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 K Burial 2 Cremation 3 K Removal from State King David Memorial 4 ☐ Donation 5 ☐ Other (Specify) 01/16/2011 Falls Church, VA 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Danzansky-Goldberg Memorial Chapels, Inc. 1170 Rockville Pike, Rockville, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Debility, Unspecified months Medical Due to (or as a consequence of): **Examiner** Senile Dementia years anwritistly list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 ☐ Live Birth 2 ☐ Fetal death

4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Dav Pregnant at time of death 1 Yes 2X 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available 24a. Was an autopsy performed? Yes 2 1 No prior to completion of cause of death?

1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗆 Yes Assisted Living 2 2 **X**No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6X Other (Specify Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No s after death.

I Director: After to in by the funera 28b. Time of 28d. Describe how injury occurred Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a

To the Funeral D

completed filled in Medical 29a. Certifier 1 🔁 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Cartifying Navse Practionel. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier License number 29d. Date signed (Month, Day, Year) 10 D38457 January 14, 2011 30. Name and address of person who completed gause of death (Item 23a) (Type, Print) Nakul Goyal, Mb, 3801 International Drive, #211, Silver Spring, Maryland

State

Registrar

31. Date filed (Month, Day, Year)

JAN

18 201

Baltimore, Maryland 21215-0036

Box 68760

Division of Vital Records, P.O.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Ira Vincent Beasley  $20\overset{\circ}{1}$ January 15:23 P M Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Clinton Prince Georges 5. Social Security Numbe 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, You Sept. 26, 7. Age (In yrs. last birthday, **Funeral** 9. Birthplace (State or Foreign Months Days Hours 77 579-48-7352 1933 Washington, DC Director Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits 1 X Yes 2 No Washington, DC 10e. Street and Number ō 10f. Zip Code 10g, Citizen of What Country? er than "natural", or items 23a of Funeral 4209 Barker Lane SE 20019 USA within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 Married Black, White, etc. þ Maryland 21215-0036 1 ☐ Yes 2 X No Specify. 3 Widowed 4 Divorced 53-55 Completed Year or Dates. Black 15. Decedent's Education 16a. Decedent's Usual Occupation permit. Page 1 and 2 should be filed within 72 h. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "n. any injury or other traumatic event, the Medic once. 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) <u>Printing Specialist Manager</u> Fed. Govt. (Navy Dept) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Charles Beasley Josephine Duvall 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Delores Beasley/ Wife 4209 Barker Lane SE Washington, DC Baltimore, 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Quantico National 1/28/11 Triangle, VA 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Priogen Funeral Service, PA 9013 Annapolis Rd. Lanham, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Myocardia Acute Medical Due to (or as a consequence.) Examiner Ischemic Cardiom Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of). To the Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-transit Encepha that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? |≥ Completed 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy perform this certificate 1 Yes Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 X No Other: ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) eral Director: After thi filled in by the funeral 28a. Date of Injury (Month, Day, Year) Certificate: 27, Manner of Death 28c. Injury at 28b. Time of 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 7 the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 01/20 30. Name and address of person who completed cause

Registrar

DHMH 17 Rev 7/2009

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State of State of Registra AMEND#10 froe TFH, 1/21/11; F			artment of I		nd M		2.0		113497	
		1. Decedent's Name (First, Middle, Last)							2. Date of Dea	Reg. No.		3. Time of Death	
	Physicia Medi		Dorothy Nell Bauer					Jan.	16, 201	6:00 a <sup>M</sup>			
-de.	Examir		4a. Facility Name (if not institution, give street and number	_	4b. City, Town, o	r Location of	Death		4c. County of Death				
-		М	3112 Gracefield Rd.,				lver				tgo	mery	
	Funeral Director		5. Social Security Number 6. Sex 7. 4 9 5 - 2 2 - 5 5 2 2	Age (In yrs. I		If Under 1 Year Months Days		Hrs. Min.	8. Date of Birth (Month, Day Aug 9	Year)	9. Birthp Coun	place (State or Foreign	
			Usual Residence of Decedent	00					Aug 9	, 1924		MO	
	yland f sho ed at	tor	10a. State 10b. County	10c. Cit	y, Town or Lo	cation					1	0d. Inside City Limits	
	Mar 28a- notifie	Director	MD Montgomery		Silv	er Spri	ng					1 🗌 Yes 2 🛂 No	
	th the		10e. Street and Number		_	10f. Zip Code				10g. Citizen of W		try?	
	ath w	Funeral	3112 Gracefield Rd.,  11. Marital Status 12. Was Decede				901	2 (0	:4 . Van an Na	USA			
(0	er de or ite niner	by F	1 Never Married 2 Married 12. Was Deceded  Armed Force 1 Yes 2	s?	5.   13. V	Vas Decedent of H Yes, specify Cuba	an, Mexican, F	Puerto R	lican, etc.)		- Americ , White, e	an Indian, etc.	
03	rs aft Iral", Exar	ed k	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates		1	☐ Yes 2 🖈 No	Specify:			Specify.White			
21215-0036	s filed within 72 hours after death with the Maryland tral Hygiene. So dother than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed)			ent's Usual Occup and of work done		f warkin		16b. Kind of Bus	iness Inc	lustry	
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37	2 should be Ith and Ment 27 is marker r traumatic e		19a. Informant's Name/Relationship (Type, Print)		19h Mailin	g Address (Street						to do l	
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Ē	Page 1 ment of ant; If it ury or o		1 ☐ Burial 2 ★ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	M.	e t rop	atory or other place olitar tcrv	,e) J	an. 2	17	Alexa	ndr	ia, VA	
Baltimore,	permit. Page 1. Department of I Important: If it any injury or or once.	j s	21. Signature of Funeral 8 wicas censee		F <sup>2</sup>	Name and Agdre O Unive	e of Facility rsity	11i E1	ns Fur vd. W.	neral H	ome er	Spring, MD	
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	hysician/	05 01	shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition  Cerebrovascular Accident  Onset ar										
mo-5°	Medical Examiner	resulting in death)  a. Due to (or as a consequence of):									3 MINS		
		<u>_</u>	Sequentially list conditions, b.										
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376	ficate g phy as the	Nedi	- 0,										
Box 687	eath certifica attending p		IF FEMALE: 23b. Was decedent pregnant 1 Live Rid	ne of pregnar		Ectopic pregnance				23d. Date	of delive	ry	
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loi:	tendi death. for: A the fu	iiii	2 Accident Investigation 3 Suicide 6 Could not be				Yes 2 No	,					
Division of Vital	or At after of Direct in by	Certificate:	4 Homicide determined 28e. Place of II	njury - At hon etc. <i>(Specify)</i>		et, factory, office		28	If. Location (Str. City or Town,	eet and Number State)	or Rural I	Route Number,	
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:	n 24 h	Medi	(Check 2   Medical Examiner: On the basis of	examination	and/or investig	ation, in my opinio	<ul> <li>n. death occur</li> </ul>	red at th	e time date and	I place and due to	the call	co(e) and manner stated	
:	vithi To th		only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and title of states 29c. License number 29d. Date signed (Month, Day, Year)										
	15	D24093 Jan. 17, 2011									2011		
			30. Name and address of person who completed cause of Mark Parkhurst Mr. 3	death (Item 2	23a) (Type, Pri								
	Chat		Mark Parkhurst, MD 3	rar's Signatu		ield R	oad,	Sil	ver Sp	ring,	M D		
	State Registra	~	JAN 18 2011	o oigilatu	book							11	

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			1 - For State Registrar	State	of Mary	•	artment c rtificate c			lental Hygie	71	1. 71 (F)	63498	
		1. Decedent's Name (First, Middle, Last)								2. Date of Death	, No.	3. Time of Death		
	Physicia Medic		Ruth	uer					January 20 2		10:40 A. <sup>M</sup>			
	Examin		4a. Facility Name (if not institution,	give street and nur	mber)				ation of Death		4c. Count	y of Death		
- '	<i>'</i>	ш	Calvert County			ederick		Cal	lvert					
	Funeral Director		5. Social Security Number 364-26-1255	6. Sex 1 ☐ M 2 🗶 F	7. Age (In )	vrs. last birthday) 87 Yrs.	If Under 1 Ye Months Da	Under 24 Hrs. Durs Min.	8. Date of Birth 01/27/21 9	ge of Birth g. Birthplace (State or Michigan				
	nd how at	_	Usual Residence of Decedent  10a. State 10b. County		100	: City, Town or Lo	cation					11	0d. Inside City Limits	
	laryla 3a-f s iffied	Funeral Director	MD Cal	ert		Prince		ick					1 ☐ Yes 2 🕅 No	
	or 28	١	10e. Street and Number			TTTMCC	10f. Zip Cod			10	g. Citizen of	What Coun		
	with s 23a lust b	era	85 Hospital Ro	oad				20678	8		U.	S.A.		
	death item item		11. Marital Status	12. Was Dec	edent Ever in	n U.S. 13. \	Was Decedent of	of Hispani	ic Origin? (Specexican, Puerto F	cify Yes or No-		ce - America		
9	after (l", or xamir	d by	1 ☐ Never Married 2 ☐ Marr 3 ☐ Widowed 4 🔀 Divorced	ied 1  Yes If Yes, Gir	orces? 2 X No ve		Yes 2 🔀			iioan, etc.,	Specify	ick, White, e		
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baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	0.0	21. Signal of Funeral Service L		1,					isch Fune				
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			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart-failure. List only one cause on each line.  Approximate Interval Between											
F	hysician/	Immediate Cours (First										Onset and Death		
	Medical Examiner		resulting in death)	Due to		sequence of):			1	1	Λ.			
		er	Sequentially list conditions, if any, leading to immediate	b. — A	Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):									
	ted I Insit	min	cause. Enter Underlying Cause (Disease or iinjury	Buc to	(01 43 4 00118	sequence on.								
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000	rtifica ing pt e as tl	w i	IF FEMALE:								T			
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5	law rec has bee	Completed	A.	vid Fil	Ma	tus				24a. Was an	24b.	Were autops	sy findings available	
ב ב	The Iz	S	P	e plier	1	) a scul	~ D	Sea	ge	autopsy performe 1  Yes 2	1?	prior to completion of cause of death? 1 ☐ Yes 2 ☐ No		
9	cian: ertific ector,	a B	25. Was case referred to medical examiner?	Hospital:			26	Place of	Death (Check of					
5	Physician: The this certificate had director, page	은	1 ☐ Yes 2 No  27. Manner of Death	1 28a. Date		ER/Outpatien	1 3 LI DOA		1	e 5 🗌 Residenc				
	ding th. After funer	Certificate:	Natural 5 Pending	(Mon	th, Day, Year	) injury		jury at ork? □ Yes		3d. Describe how i	njury occurr	ed		
2 :	Atten r deal ctor:	Ĕ	2 Accident Investig. 3 Suicide 6 Could n 4 Homicide determine	ot be 28e. Place	of Injury - A	t home, farm, stre				Bf. Location (Street and Number or Rural Route Number,				
5	s after s after at Dire		4 - Homode determin	buildii	ng, etc. (Spe	ecify)					or Town, State)			
	4 hour	Medical	29a. Certifier 1 Certifying (Check 2 Medical Ex	Physician: To the b	est of my kn	owledge, death o	ccured at the ti	ne, date	and place, and	due to the cause(s	and manne	er as stated	so(s) and manner stated	
27. Manner of Death   Section   Part								se(s) and ma	anner as stat	ed.				
29b. Signature and title of certifier  29c. License number  29d.									d. Date signed (Month, Day, Year)					
		-	30. Name and address of person w	ho composit caus	e of death /I	tem 23a) (Type Pi		<del>•</del>			1. 6	0-1		
Rυ	v 3		Jonathan Lower			, , , , ,	,	#31	lO, Prin	ice Frede	erick.	MD 2	0678	
	State	-	31. Date filed (Month, Day, Year)	32 D	agietrar' Sic	nature								
	Registra	r	AAI.	25 7011	Dene	un B.	park	A. C. C. C. C. C. C. C. C. C. C. C. C. C.						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Robert Donn Bennett 7:47 p M Medical 2011 January 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 2616 Winters Run Road Harford Joppa 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Months Days 1 ▼ M 2 □ F Feb. 23, 1954 219-60-7699 56 Director Yrs. Maryland Usual Residence of Decedent or 28a-f show 10b. County 10a. State Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Maryland Harford Joppa 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 2616 Winters Run Road 21085 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. "natural", or þ 1 Never Married 2 Married 1 Yes 2 X No
If Yes, Give
Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify: Completed 3 Widowed 4 Divorced Medical 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT user extredity

Selfi-Employed 15. Decedent's Education permit. Page 1 and 2 should be filed within 72 l
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "na
any injury or other traumatic event "to 16b. Kind of Business Industry (Specify only highest grade completed) Bennett Contractor, Inc Elementary/Seconday (0-12) College (1-4 or 5+) Ten Years Joppa, Maryland Carpentry Contractor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Edwin Ray Bennett Louise Virginia Suite 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sarita Bennett (wife) 2616 Winters Run Road, Joppa, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hopewell Cemetery 01/25/11 Port Deposit, Maryland 21. Signat@re of Funeral Service License 22. Name and Address of Facility
Lee A. Patterson & Son Funeral Home, P.A.
Perryville, Maryland 21903-0766 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ ETASTA disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to infinite cause. Enter Underlying Cause (Disease or iinjury Examine Directo for as a nonsequence of as the burial-transil and that initiated events resulting in death) Last Due to (or as a consequence of): physician Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death use 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No for 5 Other (specify) Month Day Year Pregnant at time of death 1 Yes 2 9 Unknown the Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? funeral director, page 2 should be Records, 1 Yes 2 No 3 Probably 4 Unknown this certificate has been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of To the Hospital or Attending Physician: The law r within 24 hours after death.

To the Funeral Director: After this certificate has b. autopsy performed? Yes 2 No death? Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 2 No ည 1 Yes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manyler of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide (Month, Day, Year) 5 Pending 1 Yes Investigation completed filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as caused. atti conumid at the time, date and place, and due to th 29b. Signature and title of dertifier 29d. Date signed (Month, Day, Year) 10

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

JAN 2 4 2011

of person who completed cause of death (Item 23a) (Type, Print)

2300

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registre MEND#8perINF, 1/14/11; BWW, McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Januaru Morton Beroza 6:45 am Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Renaissance Gardens - Riderwood Silver Spring Prince George's Social Security Number 7. Age (In yrs. last birthday) Year If Under 24 Hrs. 8. Date of Birth 3\_7\_1917 Funeral 9. Birthplace (State or Foreign 1 🛛 M 2 🗆 F Months Days Hours Connecticut Director 086-05-3368 93 Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location death with the Maryland Director 10d. Inside City Limits Maryland Silver Spring Montaomeru 1 🗌 Yes 2 🗓 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3118 Gracefield Road, CC Apt. #201 20904 u.s.A. 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 X Married þ Saltimore, Maryland 21215-0036 If Yes Give 1 ☐ Yes 2 X No Specify: "natural", 3 Divorced Specify: Completed WWII White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and 2 should be filed within 72 Health and Mental Hygiene. Iem 27 is marked other than ' U.S. Department of Elementary/Seconday (0-12) College (1-4 or 5+) Chemist Agriculture Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jacob Beroza Tina Chatzek 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16750 Whites Store Road, Boyds, Maryland 20841 Robert J. Beroza - Son Department of Hea Important: If item 20a. Method of Disposition Page 1 g 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 X Removal from State cemetery, crematory or other place injury or 4 ☐ Donation 5 ☐ Other (Specify) King David Mem. Grdns 01/14/2011 | Falls Church. VA Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, any thre Manewarks 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph\_sician/ disease or condition resulting in death) Pneumonia Medical Due to (or as a consequence of): Examiner Advanced Dementia Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burlat-tighnist Anemia that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Pregnant at time of death 9 Unknown a | Unknown cate has been signed by the page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🗓 No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? 2 🗌 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 □ only one)

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Loulen

Loveen J. Puthumana,

JAN 18

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.,

32. Registrar's Signature

D59524

3110 Gracefield Road, Wilver Spring, Maryland 20904

29d. Date signed (Month, Day, Year)

January 12, 2011